

# Healthcare Transformation Collaboratives Cover Sheet

**1. Collaboration Name:**

Youth and Family Behavioral Health Collaborative

**2. Name of Lead Entity:**

Methodist Medical Center of Illinois

**3. List All Collaboration Members:**

Methodist Medical Center of Illinois; The Board of Trustees of the University of Illinois / University of Illinois College of Medicine Peoria; UnityPoint Health - UnityPlace; Children's Home of Central Illinois; Heartland Health Services; Hult Center for Healthy Living; Human Service Center (a subsidiary of UnityPlace); Tazwood Center for Wellness (a subsidiary of UnityPlace); Tri-County Urban League.

**4. Proposed Coverage Area:**

The Tri-County Area, which includes Peoria, Tazewell, and Woodford counties, with specific focus on Peoria County and zip codes 61603, 61604, 61605.

**5. Area of Focus:**

The Youth and Family Behavioral Health Collaborative is focused on improving access to and delivery of child and adolescent behavioral health, mental health and substance abuse treatment services through transformative treatment facilities and programs.

**6. Total Budget Requested:**

\$35,868,405.00

## 1. Participating Entities

### 1. Are there any primary or preventative care providers in your collaborative?

Yes

#### 1A. Please enter the names of entities that provide primary or preventative care in your collaborative.

Methodist Medical Center  
Heartland Health Services  
University of Illinois College of Medicine Peoria  
Hult Center for Healthy Living

### 2. Are there any specialty care providers in your collaborative?

Yes.

#### 2A. Please enter the names of entities that provide specialty care in your collaborative.

Methodist Medical Center  
Children's Home Illinois  
Heartland Health Services  
Human Service Center  
Tazwood Center for Wellness  
University of Illinois College of Medicine Peoria

### 3. Are there any hospital services providers in your collaborative?

Yes

#### 3A. Please enter the name of the first entity that provides hospital services in your collaborative.

UnityPoint Health – Methodist Medical Center

#### 3B. Which MCO networks does this hospital participate in?

- ☐ YouthCare
- ☒ Blue Cross Blue Shield Community Plan
- ☐ CountyCare Health Plan (Cook County only)
- ☒ IlliniCare Health
- ☒ Meridian Health Plan (Former Youth in Care only)
- ☒ Molina Healthcare

**4. Are there any mental health providers in your collaborative?**

Yes

**4A. Please enter the names of entities that provide mental health services in your collaborative.**

Methodist Medical Center  
Children's Home Illinois  
Heartland Health Services  
Human Service Center  
Tazwood Center for Wellness  
University of Illinois College of Medicine Peoria

**5. Are there any substance use disorder services providers in your collaborative?**

Yes

**5A. Please enter the names of entities that provide substance abuse disorder services in your collaborative.**

UnityPoint Health – UnityPlace  
Heartland Health Services  
Human Service Center  
Tazwood Center for Wellness  
University of Illinois College of Medicine Peoria

**6. Are there any social determinants of health services providers in your collaborative?**

Yes

**6A. Please enter the names of entities that provide social determinants of health services in your collaborative.**

Children's Home Illinois  
Hult Center for Healthy Living  
Tri-County Urban League  
Human Service Center

**7. Are there any safety net or critical access hospitals in your collaborative?**

No.

**7A. Please list the names of the safety net and/or critical access hospitals in your collaborative.**

N/A

**8. Are there any entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that are majorly controlled and managed by minorities?**

Yes.

**8A. Please list the names of the entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that are majorly controlled and managed by minorities.**

Tri-County Urban League.  
The University of Illinois College of Medicine Peoria.  
Hult Center for Healthy Living

**9. Please list the Medicaid-eligible billers (firms that can bill Medicaid for services) in your collaborative, and the Medicaid ID for each.**

UnityPoint Health – Methodist Medical Center  
Children’s Home Illinois  
Heartland Health Services  
Human Service Center  
Tazwood Center for Wellness  
University of Illinois College of Medicine Peoria

**10. Below are high-level descriptions of project types that appeared in the Transformation funding statute. Check any that apply to your project; if none apply, please provide a brief description of what kind of entities comprise your collaboration.**

- ☐ Safety Net Hospital Partnerships to Address Health Disparities
- ☐ Safety Net plus Larger Hospital Partnerships to Increase Specialty Care
- ☒ Hospital plus Other Provider Partnerships in Distressed Areas to Address Health Disparities (led By Critical Area Hospitals, Safety Net Hospitals, or other hospitals in distressed communities)
- ☐ Critical Access Hospital Partnerships (anchored by Critical Area Hospitals, or with Critical Area Hospitals as significant partners)
- ☐ Cross-Provider Care Partnerships Led By Minority Providers, Vendors, or Not-For-Profit Organizations
- ☒ Workforce Development and Diversity Inclusion Collaborations
- ☐ Other

**10A. If you checked, “Other,” provide additional explanation here.**

N/A

## 2. Project Description

### Brief Project Description

#### 1. Provide an official name for your collaboration.

Youth and Family Behavioral Health Collaborative

#### 2. Provide a one to two sentence summary of your collaboration's overall goals.

The Youth and Family Behavioral Health Collaborative (“**YFBHC**” or the “**Collaborative**”), comprised of community organizations, healthcare systems, and organizations of higher education serving Illinois’ Peoria, Tazewell and Woodford Counties, aspires to develop and execute an integrated, evidence-based model of behavioral healthcare for children, adolescents and their families.

### Detailed Project Description

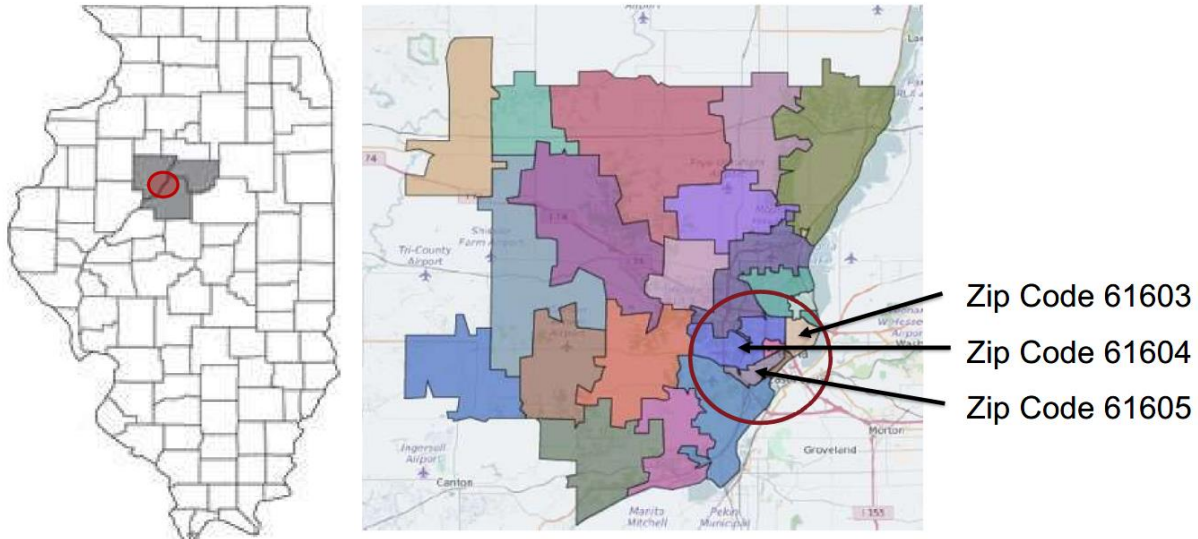
The YFBHC will provide a complete range of behavioral healthcare services to meet the needs of the area’s families, including: greater access to care; comprehensive diagnostic and needs assessments in a welcoming and accessible centralized hub; synergetic and complementary direct and indirect services by an integrated team of practitioners; empirically-based treatments; a focus on social determinants of health and a unified approach to addressing markers of inequality (such as food insecurity, health illiteracy, cultural barriers to care, financial instability, and safe spaces for relaxation and physical exercise); attention to clinical and consumer-based outcomes; and, efforts to innovate in a manner that is specific to the community. Two key elements of the YFBHC will be to optimize community engagement and to develop a steady and reliable workforce. Community engagement efforts will include broad-based stakeholder input through all stages of planning and execution and will realize diversity and inclusion goals. On-site outreach services, such as in schools and in the neighborhoods, will help address issues of access while ensuring opportunities for the full range of comprehensive behavioral health offerings. The YFBHC will implement a pipeline recruitment program designed to expand and diversify the behavioral health workforce.

The goal of this Collaborative is to:

- Utilize patient centered, evidence-based approach to mental and behavioral health care in the community that integrates the best practices with compassionate and high-quality care.
- Implement a coordinated approach to management of community health mental and behavioral needs of the youth and children in the community.
- Design programs and evaluation criteria and partners with qualified community-based organizations to launch and study the impact of the pilots in the community.
- Develop and implement professional pipeline programs to aide in the development of a more robust and diverse workforce providing comprehensive mental and behavioral health services in the region.

### Service Area:

The Youth and Family Behavioral Health Collaborative “YFBHC” or the “**Collaborative**”) is focused on improving access to and delivery of child and adolescent behavioral health, mental health and substance abuse treatment services through transformative treatment facilities and programs in Peoria, Tazewell and Woodford counties (the “**Tri-County Area**”), which will specifically benefit the distressed areas in Peoria County and the high-risk zip codes 61603, 61604 and 61605.



### Healthcare Challenges:

Peoria County, specifically zip codes 61603, 61604 and 61605, are among the most distressed in the nation. The CDC Social Vulnerability Index measures Peoria County at 0.6131, indicating a moderate to high level of vulnerability. <sup>1</sup> Peoria’s unemployment rate is higher than the state average and has been since 2013. <sup>2</sup>

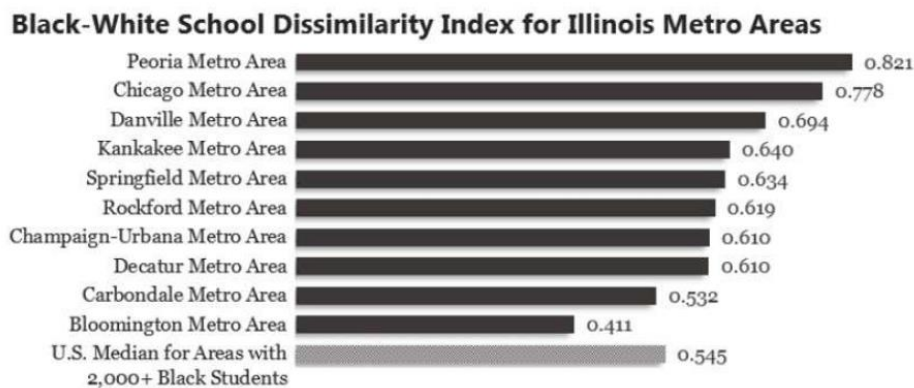


Source: [https://svi.cdc.gov/Documents/CountyMaps/2018/Illinois/Illinois2018\\_Peoria.pdf](https://svi.cdc.gov/Documents/CountyMaps/2018/Illinois/Illinois2018_Peoria.pdf)

Although there are many healthcare needs in Peoria and the surrounding counties, behavioral health care is one of great concern. When residents were asked about the area's most pressing health need as part of the 2019 Community Health Needs Survey ("**CHNA**"), 69% of survey respondents identified mental health as the most important health issue in the community.<sup>3</sup> Moreover, approximately 1/3 of respondents admitted they experienced depression or stress in the last 30 days.<sup>4</sup> Nearly a tenth of the community, 8% of survey respondents, described their mental health as "poor," and only 28% of respondents stated that their mental health was "good."<sup>5</sup>

Furthermore, in the Tri-County Area, 31.3% of 10th grade students indicated that in the past 12 months they felt sadness or hopelessness almost every day for at least 2 weeks, causing them to stop participating in some of their usual activities. 16.7% of 10th graders indicated they seriously considered attempting suicide in the past 12 months.<sup>6</sup> Data from the 2018 Youth Survey measured illegal substance use among adolescents and found that Peoria County is at or above the state averages for substance use in all categories among 8th and 12th graders.<sup>7</sup> According to the National Institute of Mental Health ("**NIMH**") and National Alliance on Mental Illness ("**NAMI**"), delays in treatment contribute to the fact that 40% of students with mental illness drop out of high school.<sup>8</sup> Those same organizations have reported that suicide is the second leading cause of death in children ages 10-34 years.<sup>9</sup>

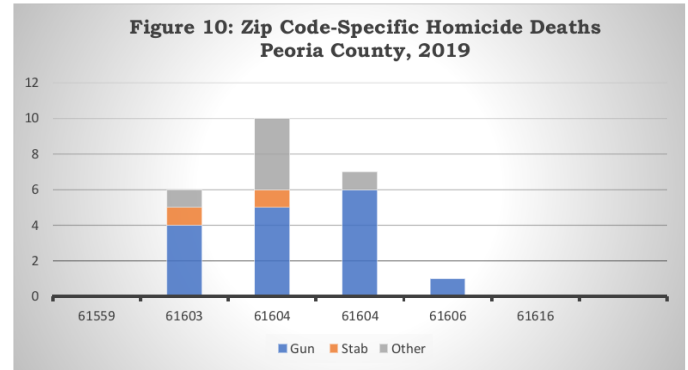
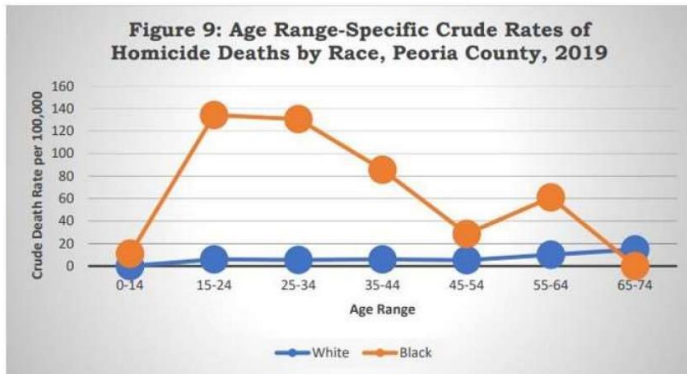
These mental health concerns are not surprising given the repeated and sustained trauma the youth experience. Systemic racism exists in this Community and impacts its youth. According to published school segregation data, Peoria area schools are more segregated than any other area in the state.<sup>10</sup>



Source: Vock, D. and Maciag, B., *Still Separate After All These Years: How Schools Fuel White Flight*. January 19, 2019 (Available at: <https://www.governing.com/archive/gov-segregation-schools.html>)

Peoria also makes national headlines for its murder rate; CBS has listed Peoria as having the 15<sup>th</sup> highest murder rate in the country.<sup>11</sup> This is supported by the fact that the crime rate in Peoria for 2019 was 1.8 times higher than the U.S. average.<sup>12</sup> From 2017 to 2019, the murder rate doubled.<sup>13</sup> Homicide deaths also impact persons of color disproportionately.<sup>14</sup>





Source: Peoria County Mortality Report, p. 21. (2019)

The children and adolescents in the community are exposed to this violence and the repeated trauma of their experiences can create mental health issues that need to be addressed to improve their well-being. This is compounded by the systemic racism that exists in the community and its impact on the youth. According to published school segregation data, Peoria area schools are more segregated than any other area in the state.<sup>15</sup> Peoria County struggles with poor school performance, demonstrated by low graduation rates and chronic truancy.<sup>16</sup> But more troubling is the fact that the two leading causes of death for persons age 15-24 in Peoria County are homicide (52.9%) and suicide (11.8%).<sup>17</sup>

**Table 8: Leading Causes of Death (% of total deaths within age category), by Age Range, Peoria County, Illinois 2019**

| Rank | Age Range           |                 |                 |                 |                      |                           |                             |                            |
|------|---------------------|-----------------|-----------------|-----------------|----------------------|---------------------------|-----------------------------|----------------------------|
|      | 0-14                | 15-24           | 25-34           | 35-44           | 45-54                | 55-64                     | 65-74                       | 75+                        |
| 1    | Pre-maturity (35.0) | Homicide (52.9) | Overdose (20.0) | Overdose (20.3) | Heart Disease (23.9) | Cancer (35)               | Cancer (31.7)               | Heart Disease (26.3)       |
| 2    | Asphyxia (15.0)     | Suicide (11.8)  | Homicide (20.0) | Cancer (14)     | Cancer (29.5)        | Heart Disease (23.5)      | Heart Disease (20.6)        | Dementia (14.6)            |
| 3    |                     |                 | Suicide (8.6)   | Suicide (12.5)  | Overdose (8.5)       | Accident/Injury (6.9)     | Respiratory Disease (11.6)  | Respiratory Disease (10.8) |
| 4    |                     |                 |                 | Homicide (6.3)  |                      | Respiratory Disease (8.7) | Sepsis & Septic Shock (2.2) | Cancer (17.5)              |
| 5    |                     |                 |                 |                 |                      |                           |                             | Stroke (3.4)               |
| 6    |                     |                 |                 |                 |                      |                           |                             |                            |

Source: Peoria County Mortality Report, p. 10. (2019)

Despite recognizing the importance of their mental health, residents in the Tri-County Area are not seeking treatment. The 2019 CHNA revealed that Peoria County residents often choose not to seek medical care because of co-pay obligations, long wait times, lack of insurance and lack of transportation. The Institute of Medicine's Committee on Understanding and Eliminating Racial and Ethnic Disparities in Healthcare found that barriers that prevent or limit access to needed healthcare services may increase the risk of poor health



outcomes and health disparities; this places marginalized communities, like Peoria County and other parts of the Tri-County Area, at a higher risk for developing health issues, despite our above-average availability of healthcare services. In fact, Peoria County ranks "Much Worse than Average" for overall adolescent health compared to the rest of the state.<sup>18</sup> Utilization of services is what drives positive health outcomes.

Identifying that physical and mental health are a problem in Peoria, and in response to recent protests about racial injustice, a council member (now the current mayor), and the former mayor, convened a group called the Healthcare Collaborative to address health equity. This group determined that the best way to understand the needs of the community is to engage the members of the community through conversation. To this end, focus groups for residents of the vulnerable zip codes of 61603, 61604, and 61605 were conducted on topics of colon cancer, cervical cancer, and mental health in both English and Spanish. These groups were led by trusted community members at community-based organizations. From this came further evidence of the desperate need for better behavioral health support for both children and adults. Specifically, concerns were voiced about the lack of providers people can afford, the wait times, the lack of providers of color, the lack of providers who listen, and other barriers to care such as transportation. Although these groups were held with adults, issues of child behavioral health arose as well, including the need for additional mental health providers and the trauma, including things like bullying that children and youth face.

The data and the community voices echo the Collaborators' own experiences. For example, at UnityPoint Health - Methodist ("**Methodist Medical Center**") 15.9% of all child and adolescent behavioral health admissions are for patients from the three target zip codes. Of those patients, 55.5% are racial minorities (Hispanic/Latinx, black/African American, multiracial). Of those patients seen in the mental health clinic, 27.4% come from the three target zip codes and 44.7% of those patients are minorities. Of the behavioral health evaluations performed on minors in the Emergency Department, 25% of the minors are from the three target zip codes, 51.5% of which are racial minorities. Although this data shows the clear utilization of mental health care, it is likely that this is just an underestimate, as behavioral health problems can often manifest as stomach aches, headaches, or other health conditions, that are not always clearly linked to a mental health problem.<sup>19</sup>

Additionally, in the last five years, that hospital had to turn away more than 2,600 children and adolescents in need of inpatient behavioral health, mental health, or substance use treatment due to lack of capacity, insufficient staff and not having resources to address the patients' acuity. The number of children turned away per year has been steadily increasing with 1,493 children and adolescents (approximately 500 per year) in 2016 to almost 600 children per year by 2020 due to lack of available beds or the patient's acuity exceeding hospital resources. The other two closest hospitals with child/adolescent AMI beds are in Springfield (75 miles away) or the Quad Cities area (90 miles away). The YFBHC seeks to fill these gaps so that patients requiring mental health services can receive quality, affordable care while remaining in their community, near their families and support systems. The distance needed to travel for care is particularly challenging for families without a vehicle, a common experience for those in living in the 61603, 61604, and 61605 zip codes where more than 13.21% of individuals do not own a vehicle.<sup>20</sup> When mental healthcare for children and adolescents must be outsourced, families must make the difficult decision whether sending their child away is worth the treatment. Separating families during a mental health crisis adds to the stress and, for many, makes getting help seem impossible.

The data above present a clear need for more services, and, while there are individuals who would be able to provide some of these services, these practitioners have ended up leaving the area. Over the past eight years, 11 residents from the Psychiatry Training Program at the University of Illinois College of Medicine Peoria, who were interested in specializing in child and adolescent healthcare, had to go elsewhere to retrieve this advanced training because there is no Child and Adolescent Psychiatry Fellowship program in the region. To keep up with the growing need, a local mental health training pipeline needs to be established in this region.

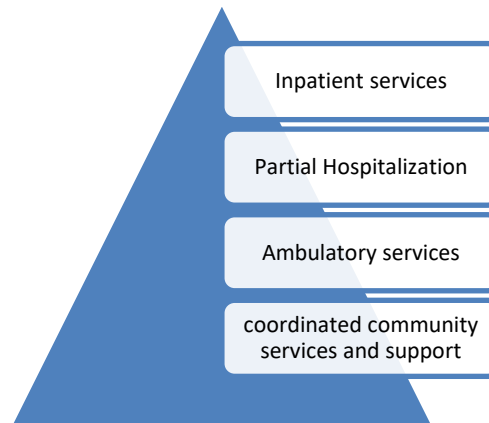
In addition to staffing and resource shortages, each of the Collaborators have encountered families and children in crisis who have expressed being overwhelmed by “the system” and who struggle to find the time, resources and strength to pursue all of the services needed to help their child heal, grow and succeed. The Collaborative encounters clients, patients and families who have been “turned off” and overwhelmed by the fact that they need to seek multiple therapies and treatment from different providers and entities in various locations. To successfully treat and recover from these illnesses, it is imperative that providers of behavioral health, mental health and substance abuse treatment develop a coordinated system that allows all families, regardless of income or race, to pursue coordinated, efficient, and quality services when necessary. No family should be forced into an extended period of crisis because of long wait lists and a lack of providers who do not accept their insurance. No child should have to continue to revisit their trauma by completing multiple similar assessments with new faces and different providers. And no parent should have to choose between their child’s healing and other financial obligations. This collaborative knows it can and must do more for children and adolescents in the community and proposes a transformational model that will make a meaningful difference in the lives of children and families in the Peoria and Tri-County Area.

### **Plan to Address These Challenges:**

The YFBHC is the product of a larger Healthcare Collaborative initiative, which determined that mental health should be a priority for health equity based on the data gathered from the focus groups mentioned above. This subcommittee of the YFBHC was then formed to address this problem, and decided to prioritize the behavioral health of children and families as a first step. The YFBHC includes nine (9) agencies, including

- Unity Point Health, (a large healthcare system in the region with expertise in mental healthcare),
- University of Illinois College of Medicine Peoria (“**UICOMP**”) (regional campus for one of the largest medical schools in the country with strong academic expertise),
- Heartland Health services (an FQHC focused on care to the vulnerable population, PCCHD), and
- other community-based organizations that focus-on children and family services.

The objective of this collaborative is to create a unified, coordinated model of care that is focused on a community oriented, convenient family center and behavioral health hub that welcomes the community and its families and provides coordinated care and support for the Peoria-area youth, regardless of race, income or ethnicity. From this behavioral health hub, outreach work into the schools and other parts of the community will be coordinated. The emphasis is to help support the community where they live, learn, work and play, with a focus on both treatment and prevention. Furthermore, this hub and spoke model will also help address the needs of the community and population from a community-based approach across the continuum of care as outlined below.



Importantly, based on the feedback received from the community, the Collaborative will also address the social determinants of health and address access to care, healthcare literacy, and work force development.

### **I. The YFBHC Will Develop and Implement a Transformational Coordinated Behavioral Healthcare Hub of Integrated Care**

Based on the feedback and input from the focus groups, this proposal was developed to transform the current model for care delivery into a hub and spoke model designed to increase access to child and adolescent behavioral health care across the continuum, reduce inpatient readmissions, and implement outreach services and educational programs to improve health literacy. The hub will not only provide coordinated community services but also provide easy access to ambulatory and inpatient facilities so that patients can easily transition from one clinical context of care to another. Furthermore, these transitions in care will be effectively coordinated through the hub so that services ranging from counseling, support services for the family, family education and proactive education can be provided both in the hub and outreach in the community such as schools. As patients progress through the levels of service provided at and in the Hub, Collaborators can ensure improved participation for better outcomes. This hub model connecting the Collaborators will include:

- Family Navigators
- Shared common assessments, service plans, and tools
- Safe space and core physical hub for Child and Adolescent Behavioral Healthcare
- Integrated provider and agency coordination

#### **A. Family Navigators**

The collaborative will develop and implement a family navigator program to help patients and families establish and access the services they require. The YFBHC will recruit and train enough Family Navigators to provide at least one navigator for every 20 families who qualify for their services. (For high acuity clients, the ratio will be reduced to 1:12.) The Family Navigators will serve as a primary point of contact and a conduit to facilitate timely appointments, services, tools, and resources for appropriate and qualifying patients. For

example, when confronted with insurance coverage issues, waiting lists and other issues that would otherwise prevent timely intervention and full engagement, the navigator can intervene and assist to keep the patient and family motivated, involved and engaged in the service plan. Navigators can also facilitate inter-provider meetings with patients and families when appropriate or necessary. The collaborative will develop the family navigator program to determine when to assign a navigator and when a patient and family no longer need a navigator having surpassed certain benchmarks.

As part of their training, the navigators will work with and become integrated with every agency's programs, services, supports and processes in order to provide effective outreach and connect their families to the right resources at the right time based on current needs and/or obstacles. They will also receive compassion and implicit bias training, thereby ensuring they are equipped to work with all individuals and all circumstances.

### ***B. Shared Assessments, Service Plans and Tools***

Children who receive behavioral and mental health services often require multiple services and supports from various providers that serve different levels of acuity. Although a family navigator will help patients find the services they need, the Collaborators understand the need to improve the patient experience and minimize inefficiencies.

Patient experience is impacted by long wait times, patients typically undergo a long, uncomfortable assessment with each separate service provider. These repeated assessments delay the ability to initiate treatment and often force children to revisit traumatic experiences multiple times with multiple providers.

In an effort to reduce stress and streamline service planning across all providers, the Collaborative will develop and implement a single, comprehensive assessment that will be used by all providers. This endeavor will avoid wasted time, and resources and will improve patient and family engagement at an early stage. Family Navigators will also be trained on how to use the shared assessment to assist families with their social determinants of health ("**SDOH**").

Along with the shared assessment, the Collaborators will develop and implement a shared service plan tool so that the family navigator and all providers are aware of the services and supports that have been recommended, are being utilized, have been completed, are in progress or have been successful/unsuccessful. By accessing this information, each provider can understand how their services and supports fit into the patient's healing map and how their health journey is impacted by various SDOH. Clinicians, therapists, and counselors should know what other services are in place for the patient – but they should also know if the patient is receiving services in school or assistance with residential placement or food insecurity. When providers have more information about the patient's needs, they can better meet the patient where they are and help the patient take the next best step given other challenges and obstacles they are facing at that time.

The final piece to improve outcomes will be the Collaborators adoption of empirically supported treatment approaches. In so doing, providers will employ approaches proven to effect positive patient results across a broad range of behavioral health problems. By adopting common treatment platforms, providers and patients will speak a unified language, allowing seamless movement within system and across the continuum of care.

Patients and families will be empowered to advocate for themselves and develop more sustained independence through familiarity of language and treatment goals. For example, for individuals suffering from traumatic events, the Collaborators may guide providers to follow approaches advocated by the National Council for Behavioral Health's Trauma-Informed, Resilience-Oriented Approaches.

***C. Safe Space and Core Physical Hub for Child and Adolescent Behavioral Services Across the Healthcare Continuum.***

At the core of this proposal is a new, state-of-the-art, child and adolescent behavioral health facility that will provide essential resources and space for skilled area providers to serve children and families in one welcoming, convenient, and central location. This "Hub" will be home to both inpatient and outpatient mental health, behavioral health and substance use treatment, therapies, and resources. Expansion of space will allow the Collaborative to continue to provide services to all individuals regardless of payor source, including providing Medicaid-covered services as well as low- and no-cost services.

In addition to the inpatient psychiatric services provided at the proposed center, there will be embedded outpatient and primary care offices to provide a full continuum of mental health and substance use care for children, adolescents, and their families. Presently, UnityPoint Health – Central Illinois operates a 23-bed child and adolescent unit within Methodist Medical Center in Peoria, Illinois. This unit is part of the region's most comprehensive continuum of care for behavioral health and has served tens of thousands of children over the past 30 years. The current child and adolescent unit is located on the 8<sup>th</sup> floor of Methodist Medical Center and was built in 1917. In 1988, the building was renovated to include the current child and adolescent unit. Since that time, only repairs to the unit have been completed.

Due to limited space in the existing unit, 23 beds are not enough to accommodate the demand for services. And the unit's design – a long hallway within a hospital setting, with no way to segregate high acuity patients – is not conducive to current treatment modalities. This is one of the reasons more than 2,600 children were denied services since 2016.

Building a new and larger center will serve Illinois' children, adolescents and their families through increased bed capacity, increased flexibility to address acuity and diagnostic concerns, integration of inpatient and outpatient services, and coordination of physical and mental health services

The inpatient center will bring necessary, updated improvements to the care provided to Tri-County residents in the form of:

- Expanded overall bed capacity from 23 to at least 43 adolescent behavioral health beds
- Improved access to treatment services by doubling the number of skilled psychiatrists and counselors
- The first unit specializing in the care of children with Autism and Asperger's
- The region's first behavioral health ICU to accommodate high acuity patients
- A new intensive outpatient program to reduce inpatient admissions
- A 24/7 crisis center to avoid unnecessary Emergency Department visits
- Recreational and experiential spaces including, recreational/exercise space, art therapy, music therapy and a sensory room to provide alternative forms of healing and treatment

- Space for support groups for children and parents
- Different “neighborhoods” for children and adolescents, with adolescents separated by gender.

The Hub will also be home to a new Intensive Outpatient Program (“**IOP**”) to provide higher acuity services daily and in an outpatient setting. IOP’s for adolescents typically provide three hours of therapy after school — providing crucial intervention and support services in a nurturing environment while allowing the child to continue with their traditional school day and remain in their home environment overnight. The IOP program will focus on dialectical behavior therapy (“**DBT**”), a comprehensive, evidence-based treatment. There is currently no such program offered in the Tri-County Area, and an IOP program will allow area providers to provide essential treatment and services without inpatient admissions and avoiding costly, wasteful Emergency Department visits.

The adjacent outpatient and community center will provide a comfortable, convenient, positive, and trusted space for families and children to see providers, counselors, therapists, and other service providers (individually and in group sessions) in one convenient location. Childcare, transportation services and other essential services will be offered to help families overcome the barriers that too often block access to care and detract from patient engagement. The center will also provide space where families can receive social services, support and advice that is a critical piece in the treatments, therapies and services provided at the Hub. For example, the outpatient center will serve as the “home base” for the Family Navigators and will be staffed with trained concierge receptionists who can help refer inquiring families to resources. The center will offer spaces and offices for families to receive behavioral health supports and services from Collaborators and other community partners. The center will also host support groups, health fairs, food drives, and education seminars for community families and youth.

By locating the outpatient center immediately adjacent to the child and adolescent inpatient center, children, adolescents, and their families will benefit from earlier and greater cooperation and coordination between inpatient and outpatient services and aide in a smooth transition between care levels. By introducing and connecting patients and their families to outpatient providers and necessary community services while receiving inpatient care in the same building, the Collaborators can surmount the social determinants of health that create obstacles to successful transitions, outpatient engagement and persistent healing. Through improved care coordination, the transition from inpatient to outpatient care will be optimized, better connecting youth and families with appropriate services that meet their needs.

This Hub model will be specifically built and designed to support increased access to child and adolescent behavioral health care, reduce inpatient readmissions and improve student outcomes by expanding access to quality, high-acuity care in the community. As patients progress through the levels of service provided at and in the Hub, Collaborators can ensure improved participation for better outcomes.

#### ***D. Integrated Agency Coordination***

Finally, by developing the Collaborative, these related service and healthcare providers will necessarily come together and meet regularly to:



- Facilitate ongoing conversations between organizations to identify gaps in services and care and develop a coordinated approach to enhance patient care services.
- Facilitate opportunity for bidirectional conversations between the health care navigators and the collaborators on challenges and needs for the patients.
- Provide a forum for education of the family navigators on available resources in the community
- Create a shared repository of community resources that can be made available to the healthcare systems and the community.
- Foster structured communication and coordination of referrals for the benefit of Tri-County area's children and family.
- Develop and streamline processes to enhance efficiency and ensure consistency in the patient education.

## **II. The Collaborative will Expand their Integrated Care Model into the Community and Schools**

With increased coordination, more efficient care delivery and more counselors, therapists, and professionals, each of the Collaborators will be able to develop more robust, proactive outreach programs and deliver their services to the Peoria-area schools and the community. This will bring the resources to where our vulnerable populations learn, providing the tools that can help them cope in stressful situations and view others with compassion. Empowering teachers with much-needed developmental and technical support to address the emotional difficulties facing children today will expand the impact.

Each collaborator already has well-developed community-based programs and services that each delivers to the community. Utilizing shared resources in the form of navigators, shared assessments, shared service plans and evidence-based programming, the YFBHC can become more efficient. The implementation of navigators will free up counselors and therapists to focus on counseling and therapy, rather than appointment planning and referrals. Shared assessments and service plans will allow each entity to receive critical background information and allow services to begin at the first appointment instead of the second or third. These increased efficiencies will increase the Collaborators capacity to do more of what they do best such as:

- Growing the number of Safe Zones and safe spaces for those identifying as LGBTQ+, in partnership with community partners, such as Central Illinois Friends and Hult Center for Healthy Living.
- Providing trauma-informed education and training to increase number of trauma-responsive schools in community in partnership with community partners, such as local Regional Offices of Education and Lifting Up, LLC (a software tool to automatically generate notification among first responders and schools when a child experiences an adverse experience at home).
- Increasing social-emotional learning among the Tri-County area's youth.
- Expanding suicide prevention and awareness programming.

The University of Illinois College of Medicine Peoria's Center for Wellbeing will expand its current efforts into the Peoria Public Schools and other area school districts. Evidenced based programs for teachers and administrators, such as Emory University's Social, Emotional and Ethical ("SEE") Learning workshops will be provided to extend the impact from teachers to students and families. Educational services will be provided to students in areas such as compassionate self-care, health literacy, improving resiliency, anti-bullying, conflict

resolution, and effective communication. A pilot model for these and other Center for Wellbeing services has been successfully implemented in a local school in a manner that is easily adaptable and scalable. Hult Center for Healthy Living will similarly be able to increase the number of Peer Educators in Peoria high schools using NASPA's Certified Peer Educator training; Peer Education is an evidence-based practice to improve health education outcomes, adopt health promotion and prevention behaviors, and increase access to health-related resources. Children's Home can expand its mental health work in the Community and in schools by being able to refer to and utilize the Collaborative's outpatient psychiatric services. Many families are reluctant to work with providers who do not have the capability of involving psychiatry services. Through this Collaborative, no family will be forced to "shop around" for providers that are able to meet most of their needs. Instead, this Collaborative will allow families to work with a unified group and that can, collectively, meet all their needs in an efficient, coordinated way.

The YFBHC believes collaboration between health care providers is a key strategy for improving patient outcomes and facilitating reform. This collaborative has been designed to embody the critical elements for a successful collaborative: accountability, communication, leadership, coordination, a shared, clear purpose, and a defined strategy. The YFBHC believes its participation in the Illinois Healthcare Transformation Program provides an extraordinary opportunity to reform and improve access and engagement, but also revolutionize the health and welfare of Peoria and Tri-County Area children and families.

### **III. The YFBHC will Develop a Sustainable Professional Pipeline to Deliver this Integrated Care**

With a state-of-the-art facility that re-envisioned how child and adolescent behavioral health care is delivered, and the hub and spoke model to grow community engagement and outreach, this collaborative can attract more clinical professionals to better serve the area's needs. To ensure recruitment of clinicians, counselors and therapists that accept Medicaid, the Collaborative seeks to develop and implement a paid internship program to attract a diverse pipeline of therapists and counselors from nearby colleges and universities to serve Peoria-area children and families in Peoria.

The Collaborative's governing body will facilitate a process by which the Collaborative will identify areas where additional providers and counselors are most needed to achieve the goals and outcomes of the Collaborative and distribute transformation funds to those entities to recruit and hire those positions with a preference for diverse persons and professionals that are a reflection of the Peoria-area community. To accomplish this, the Collaborative will develop specific initiatives to incentivize minority participation and those underrepresented in the healthcare community to increase diversity among behavioral health providers in the Peoria area.

Those funds distributed for paid internships will create a career path for local persons and students to receive the education and training to become behavioral health therapists, counselors and other professionals while accomplishing the goals of this collaborative and creating a formal pipeline for local college students to build a professional network and career in Peoria County.

The YFBHC will also support the development of a child and adolescent psychiatry fellowship. This Accreditation Council for Graduate Medical Education ("ACGME")-Certified training program will form a key pipeline for the development and recruitment of child and adolescent psychiatrists. The two-year fellowship,

the first of its kind in the region, will be an extension of the already successful general psychiatry residency training program. The general training program, founded in 2011, illustrates the positive results inherent to the strong partnership between UnityPoint Health and the University of Illinois College of Medicine Peoria (“UICOMP”). The program has been able to recruit more than three dozen medical students from more than 20 schools across the nation to train in Peoria. The program has prepared 11 graduates for advanced training in child and adolescent psychiatry, but because there are no fellowships in Peoria, these graduates have sought training elsewhere. A new YFBHC’s child and adolescent psychiatry fellowship will be an attractive recruitment vehicle for adding the requisite UICOMP faculty members, while adding service through relatively low-cost trainees. Most important, the creation of a fellowship program will serve as a pipeline for recruitment of graduate trainees. Trainees interested in this field will have the opportunity to continue their training and forge professional relationships in their local community, thereby increasing the probability that these homegrown physicians will remain in the Tri-County area.

Finally, by developing a new, state-of-the-art, coordinated system of care across all provider types, the Collaborators believe this transformational program will better attract and retain professionals who are willing to invest their careers in Peoria and are willing to deliver high-quality, Medicaid-covered care in an environment that fosters efficiency, collaboration and opportunities for research.

### **Timeframe**

Recognizing the significant time necessary to bring the Hub into operation, the Collaborative has devised a multi-phase approach to implementing its plan. (A detailed timeline is illustrated in Section 14, below). If this proposal is approved, the Collaborative will develop the steering committee, prepare and execute an affiliation agreement, develop its charter and begin meeting before any funds issue. This preparatory work will allow the Collaborators to begin implementing the proposal program towards its goals on the first month of funding.

The Collaborative has set the following schedule for each element in its proposal:

- Family Navigator Program
  - Months 1-5: Develop program metrics and benchmarks (Months 1-5)
  - Months 6-9: Recruit Family Navigators (Months 6-9)
  - Months 9-12: Train Family Navigators (Months 9-12) *\*to coincide with shared assessment being completed*
  - Beginning Month 12: Implementation of Family Navigator Program
- Shared Practice Tools
  - Months 1-3: Purchase evidence-based practice
  - Months 4-6: Train personnel on evidence-based practice
  - Months 7-10: Develop shared assessment tool
  - Months 9-12: Develop shared service plan
  - Beginning Month 12: Implementation of evidence-based practices and shared tools
- Internships

- Months 1-6: Planning (identify positions and quantity)
- Months 4-12: Recruiting
- Beginning month 10: Implementation of interns
- Fellowship Program
  - Months 1-12: Recruit core faculty, develop fellowship program and apply for accreditation
  - Months 13-16: Waiting period for approved accreditation
  - September 1 following receipt of accreditation: Fellowship recruitment begins (Fellowships follow a standard annual cycle will recruiting occurring from September – January each year. Fellows are selected in January and the Fellowship begins on July 1 each year).
- Program Evaluation
  - Months 1-6: Baseline data collection
  - Months 6-9: Baseline data analysis
  - Months 10-12: Baseline results reporting
  - Months 13-14: Data acquisition begins
  - Months 15-16: Data analysis begins
  - Months 17-18: Dissemination, discussion and review of data begins
  - Acquisition, analysis and dissemination will occur every six months
- Family Hub and Community Center
  - Months 1-3: Purchasing/Closing on property
  - Months 2-5: Design
  - Months 5-7: Bids
  - Months 5-9: Permits
  - Months 9-23: Construction
  - Months 22-24: Licensure, Certifications, Occupancy and other Approvals
  - Month 25: Opening of Hub and Community Center.

Once construction is completed, which is planned for Month 25, the Collaborative will then bring the implemented services and programs into the Hub for full implementation of the Collaborative’s plan.

Within the first year of funding, the Peoria-area will benefit from additional therapists, counselors, and Family Navigators coordinating services and supports from a central location and a coordinated system of care both in the Hub and reaching into the community and schools to capture those in need.

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<sup>1</sup> Agency for Toxic Substances and Disease Registry, *Social Vulnerability Index*, CTRS. FOR DISEASE CTRL., (Oct. 9, 2018), <https://svi.cdc.gov/map.html> [hereinafter “*Social Vulnerability Index*”].

<sup>2</sup> Partnership for a Health Community, *Community Health Needs Assessment 2019*, at 22, <https://www.pcchd.org/DocumentCenter/View/705/2019-Tri-County-Community-Health-Needs-Assessment-PDF-> [hereinafter “CHNA”]

<sup>3</sup> *Id.* at 75.

<sup>4</sup> *Id.* at 50.

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<sup>5</sup> *Id.* at 49.

<sup>6</sup> *Id.* at 81.

<sup>7</sup> *Id.* at 51, 57.

<sup>8</sup> *To Assure the Free Appropriate Public Education of All Children With Disabilities (Individuals with Disabilities Education Act, Section 618) Twenty-Third Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act, 2001*, US DEPT. OF EDUC., (Mar., 2002), <https://files.eric.ed.gov/fulltext/ED466918.pdf> [hereinafter “23<sup>rd</sup> Annual Report to Congress”].

<sup>9</sup> *Mental Health By the Numbers*, NAT’L. ALLIANCE ON MENTAL HEALTH, (Mar. 2021), <https://www.nami.org/mhstats> [hereinafter “NAMI”].

<sup>10</sup> Vock, D.C. and Maciag, M., *Still Separate After All These Years: How Schools Fuel White Flight*, GOVERNING, (January 19, 2019), <https://www.governing.com/archive/gov-segregation-schools.html>.

<sup>11</sup> Fieldstadt, E. *Murder Map: Deadliest U.S. Cities*, CBS NEWS, (Apr. 19, 2021 3:47pm), <https://www.cbsnews.com/et-pictures/murder-map-deadliest-u-s-cities/?ftag=ACQ0534a8f&fbclid=IwAR1S6frKrGhW-eMz2H8lc7b8ViMDOOtwsrSf-stEcRjmb2-YDpsTP1aSsY>.

<sup>12</sup> *Crime Rate in Peoria, Illinois (IL): Murders, Rapes, Robberies, Assaults, Burglaries, Thefts, Auto Thefts, Arson, Law Enforcement Employees, Police Officers, Crime Map*, CITY-DATA.COM, (last accessed Nov. 15, 2021), <https://www.city-data.com/crime/crime-Peoria-Illinois.html> [hereinafter “*Crime Rate in Peoria, IL*”].

<sup>13</sup> *Peoria County Mortality Report 2019*, PEORIA CITY/COUNTY HEALTH DEPT., at 21, <https://www.pcchd.org/ArchiveCenter/ViewFile/Item/660>.

<sup>14</sup> *Id.*

<sup>15</sup> *Id.*

<sup>16</sup> *Id.*

<sup>17</sup> *Id.* at 10.

<sup>18</sup> *Illinois Adolescent Health County Rankings*, Illinois Dept of Public Health Office of Women’s Health and Family Services, (Oct. 2020), <https://dph.illinois.gov/content/dam/soi/en/web/idph/files/publications/adolescent-health-county-ranking-short-summary-maps-v2.pdf>

<sup>19</sup> Helen Link Egger, E. Jane Costello, Alaattin Erkanli, Adrian Angold. *Somatic Complaints and Psychopathology in Children and Adolescents: Stomach Aches, Musculoskeletal Pains, and Headaches*, *Journal of the American Academy of Child & Adolescent Psychiatry*, Volume 38, Issue 7, 1999, Pages 852-860, ISSN 0890-8567, <https://doi.org/10.1097/00004583-199907000-00015>.

<sup>20</sup> See POLICYMAP (last accessed Nov. 15, 2021), <https://www.policymap.com/newmaps#/>.

### 3. Governance Structure

#### Structure and Processes

##### **1. Please describe in detail the governance structure of your collaboration and explain how authority and responsibility will be distributed and shared. How will policies be formulated and priorities set?**

The Youth and Family Behavioral Health Collaborative (“YFBHC”) will be governed by an affiliation agreement executed by each collaborating entity. The affiliation agreement will outline the authority and responsibility of each collaborating entity and include detailed commitments from each entity in relation to: (1) the entity’s adherence to the YFBHC’s policies; (2) the entity’s agreement to diligently pursue and achieve objectives of the Collaborative; and (3) the entity’s agreement to engage in honest dealing and to act prudently, ethically, and in good faith in all respects pertaining to the Collaborative.

The affiliation agreement will include and/or address staffing commitments from each collaborating entity (including, without limitation, titles and job descriptions of employees assigned to the Collaborative and weekly hour commitments), in kind resource commitments, and representations that each entity has certain required written policies in place (including, without limitation, policies pertaining to non-discrimination, sexual harassment, diversity, training, ethics, and record-keeping and reporting) and that the entity has the authority to enter into, and be bound by, the affiliation agreement.

The YFBHC will be governed by a Steering Committee composed of two (2) representatives from each collaborating entity (one of which will be a clinical representative, e.g., a physician, if available), and three (3) at-large community members (two of which shall be patients/clients or family members of patients/clients of one or more of the collaborating entities). A charter will be developed to guide the responsibilities and duties of the Steering Committee. The Steering Committee will meet weekly for the first three months and at least monthly thereafter based on needs unless greater frequency is desired.

The Steering Committee will:

- Develop written policies, including those related to the timely distribution of funds, and set ongoing priorities and/or objectives for the Collaborative
- Set and review ongoing priorities and/or objectives for the Collaborative
- Provide oversight of the fund distribution to ensure that it is aligned with the goals of the Collaborative and needs of the community, including determining when to hold town halls or other events to get additional community input
- Review on an ongoing basis the expenses and use of the allocated dollars
- Examine the reports of the success of the programs and discuss solutions where problems exist

#### Accountability

##### **2. How will collaborating entities be made accountable for achieving desired outcomes? How will the collaboration be made accountable for acting prudently, ethically, legally and with extensive participation from each participating entity? What methods will be used to enforce policy and procedure adherence? Collaborating entities will be bound by commitments set forth in the affiliation agreement and written policies adopted by the Steering Committee, which will include, among others, a commitment to diligently**



**pursue the objectives of the Collaborative and a commitment to engage in honest dealing and act prudently, ethically, and in good faith in all respects pertaining to the achievement of objectives of the Collaborative.**

In the event a collaborating entity fails to honor its commitments, materially breaches the affiliation agreement, or violates a written policy of the YFBHC, the collaborating entity will be subject to penalties as determined by the Steering Committee, including, among others, termination from participation in the Collaborative, relinquishment of the entity's potential "right" to receive transformation funds, and repayment of any funds received prior to the collaborating entity's termination. Furthermore, the inclusion and involvement of at-large community members will reinforce community needs and bring the community's voice to the Collaboration to ensure those needs are heard and considered.

### **New Legal Entity**

#### **3. Will a new umbrella legal entity be created as a result of your collaboration?**

No.

#### **3A. Please give details on the new entity's Board of Directors, including its racial and ethnic make-up.**

N/A

#### **4. How will you ensure direct payments to providers within your collaboration are utilized for your proposed program's intended purpose? If the plan is to use a fiscal intermediary, please specify.**

The YFBHC proposes that directed payments be distributed to Methodist Medical Center of Illinois and subsequently distributed by Methodist Medical Center of Illinois to collaborating entities in accordance with the YFBHC's written policy on the distribution of funds, as adopted by the Steering Committee, and previously approved budgets. The Steering Committee will regularly review the receipt of funds by Methodist Medical Center of Illinois, along with subsequent disbursements made to collaborating entities, to ensure appropriate uses of the funds and compliance with previously approved budgets and objectives of the YFBHC. Collaborating entities will be required to submit monthly reports to the Steering Committee detailing expenses and uses of the funds.

#### 4. Racial Equity

**High-Level Narrative - A fundamental focus of healthcare transformation is racial equity. Please provide a high level description of how the design of your proposal incorporates racial equity.**

Civil unrest in Peoria in the wake of the killing of George Floyd prompted Peoria's mayor and a local Councilwoman to convene a racial justice and equity coalition to identify opportunities to address and improve racial justice and equity in the community. This early effort led to the creation of the Joint Commission on Racial Justice and Equity. The Joint Commission's mission is to accelerate efforts to institutionalize racial justice and equity within county and city government and to advance its adoption throughout the region. One of the focused groups that emerged from this was the Healthcare Collaborative. The membership of this Collaborative includes leadership from UICOMP, Unity Point Health, OSF HealthCare, Heartland Health Service, Advanced Medical Transport of Central Illinois, and the Peoria City and County Health Department. Since then, this has grown to include Bradley University, the YMCA, and other community-based organizations. The YFBHC evolved out this Healthcare Collaborative to identify opportunities to address and improve racial justice and equity in the community with a specific focus on mental and behavioral health.

Building on this core value, the YFBHC is committed to focusing attention on developing practices and policies to address and combat racial inequities that exist in and around the delivery of care for patients with mental and behavioral health issues. Communities of color experience a disproportionate amount of trauma and attendant depression and anxiety due, at its roots, to structural racism. The Black/African American and Hispanic/Latinx communities experience more poverty, more violence, more discrimination, less education, and overall, more stress. Challenges identified by the residents of these communities in the focus groups conducted by the healthcare collaborative include a lack of education/knowledge of resources, the need for providers who are relatable and listen, the need for support groups, the lack of psychiatrists for children, the long wait times for care, the need of inpatient facilities, and the daily stress that these communities experience. In Peoria, there is a strong overlap between poverty, lack of transportation, and where people of color live.<sup>21</sup> A coordinated community care Hub, placed in the center of the most-vulnerable, most-impacted at-risk communities that will reach out to meet patients where they are will bring much-needed direct and coordinated mental health care to the children and families who need it most.

This initiative will help:

- 1) Coordinate and centralize the intake and support for children and families struggling with behavioral health issues by providing a pointed access to health care hub that includes an easily accessed physical space, services and support that can be reached by socioeconomically disadvantaged communities
- 2) Provide health literacy education through the community outreach programs that can help demystify the barriers and stigma associated with mental health
- 3) Expand outreach to the schools to provide support for teachers and students to enhance resilience/compassion and decrease bullying.
- 4) Develop a common curriculum for educating community members, law enforcement and first responders about what to do in the event of mental health crisis

- 5) Expand and diversify the mental health workforce in Peoria to help support patients of color and Latinx community
- 6) Develop a pipeline for future mental health providers through implementing internships and other educational programs in high school especially in the vulnerable zip codes of 61603, 61604, 61605
- 7) Provide a forum to continually engage with the at-risk communities through community conversations to gather feedback on the programs, and develop a shared understanding of their ongoing healthcare needs and services

By making mental healthcare no longer something of privilege, but rather something that everyone can access, disparities will be reduced. Further, teaching children resilience and compassion alongside health promotion and prevention programs in the schools will reduce discrimination, address health disparities, and help bring the younger generation one step closer towards equity.

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<sup>21</sup> See POLICYMAP (last accessed Nov. 15, 2021), <https://www.policymap.com/newmaps#/>.

## Racial Equity Impact Assessment Questions

### 1. Which racial/ethnic groups may be most affected by and concerned with the issues related to this proposal?

Mental illness knows no boundaries and has no barriers. It impacts the lives of all people, regardless of the color of their skin, ethnicity, or cultural or socioeconomic background. However, the Collaborators recognize and experience that communities of color experience a disproportionate amount of trauma due to violence, poverty, and systemic racism in their communities.<sup>22</sup> All of this, in turn, presents mental health challenges that are not as prevalent in the Caucasian population. COVID-19 has disproportionately impacted these communities creating additional mental health concerns, as seen both in the data of morbidity and mortality, but also as mentioned as a concern by community members in the focus groups.<sup>23</sup> As one member of a Black/African American focus group put it, “[The pandemic] happened so fast, so fierce, so hard, people dying around you.” And even for individuals who have not experienced a loss due to COVID-19, additional burdens come from the need to homeschool children, job loss, and added stress, which disproportionately impact people of color. Furthermore, communities of color have far less access to services and supports to address that trauma due to a lack of low-income providers, long wait times, insufficient Medicaid-covered resources, lack of transportation and a lack of knowledge about what services and supports are available. The coordinated community care Hub providing low- and no-cost services, placed in the center of these most-impacted at-risk communities that will reach out to meet patients where they are will bring much-needed direct and coordinated mental health care to the children and families who need it most

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<sup>22</sup> National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Roundtable on Population Health Improvement, *Community Violence as a Population*

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Health Issue: *Proceedings of a Workshop*, NAT'L ACADEMIES PRESS, (Jan. 17, 2017), at 2, <https://www.ncbi.nlm.nih.gov/books/NBK441708/>.

<sup>23</sup> COVID Data Tracker: *Demographic Trends of COVID-10 Cases and Deaths in the US Reported to CDC*, CTRS. FOR DISEASE CTRL., (Nov. 14, 2021), <https://covid.cdc.gov/covid-data-tracker/#demographics>

**2. Have stakeholders from different racial/ethnic groups — especially those most adversely affected or from vulnerable communities — been informed, meaningfully involved, and authentically represented in the development of this proposal? Who's missing and how can they be engaged?**

Yes. This collaborative has convened focus groups and engaged with community members from the Tri-County Area from all racial backgrounds and socioeconomic groups to identify the obstacles and barriers to healthcare that are specific to vulnerable, low-income community members and racial minorities. The focus groups and meetings allowed participants to discuss their experiences, their concerns, and the challenges they face freely and openly. Some of the main concerns voiced by the community members included a lack of providers who were relatable, the need for providers who will listen, the stigma around mental health, the need for support groups, the lack of follow-up for patients released from the hospital, the lack of resources in schools, the stress that leads to mental health problems, and the trauma experienced around COVID-19 and death. The feedback from these groups provided clear direction to this collaborative for what obstacles and barriers need to be addressed to increase access and engagement to the target population.

**3. Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed?**

Peoria County and the target zip codes have a high concentration of residents who are people of color in the region. That same area also has the most residents with income at or below the poverty level and who lack of transportation.<sup>24</sup> These factors converge to create a substantial barrier that disadvantages the community, which disproportionately disadvantages persons of color. When adequate behavioral healthcare is not available in an accessible way, those without resources are left without the means to get help. Additionally, the stress of living in poverty and sometimes having to work multiple jobs to support children leaves people living in poverty with very little time to access mental healthcare for themselves or their children, and when the services are not coordinated, it is almost impossible to find the time to go to one agency, then go to a second one and repeat the same story.

At Methodist Medical Center, 15.9% of all child and adolescent behavioral health admissions are for patients from the three target zip codes. Of those patients, 55.5% are racial minorities (Hispanic/Latinx, black/African American, multiracial). Of those patients seen in the mental health clinic, 27.4% come from the three target zip codes and 44.7% of those patients are minorities. Of the behavioral health evaluations performed on minors in the Emergency Department, 25% of the minors are from the three target zip codes, 51.5% of which are racial minorities. More affluent portions of the Tri-County Area, which is also predominantly white, tend to have more money, reliable transportation, commercial insurance with access to more specialty providers, and employment with more schedule flexibility and/or one stay-at-home parent who is able to coordinate multiple

services. Additionally, these areas also experience less food insecurity, less violence, increased safety, and more access to childcare services. Thus, coordination between a counselor and a food pantry is irrelevant for the more affluent portions of the Tri-County Area but may be critical for the less affluent regions.

Third, Peoria County and the target zip codes experience exponentially higher violence rates and the children in those areas are far more likely to experience and observe trauma related to violence.<sup>25</sup> Furthermore, when children know the victim, perpetrator, or live close to where the violence occurred, their behavioral and mental health needs are more acute.

Access to affordable care, providers that listen, providers look like their patients, support groups, and improvement of knowledge/health literacy are of paramount importance to communities of color in Peoria and this was confirmed in the focus groups run among residents of 61603, 61604, and 61605. This proposal is designed to ensure that the individuals living with the most trauma and the least resources have access to the care and support they need in their own community.

Currently, little is known about the relative levels of mental health issues broken down by racial/ethnic group and the rates at which they can seek care, particularly outpatient treatment. Unfortunately, these data for adults and children is not readily available. While the Collaborators know that all the factors that lead up to mental health issues (poverty, violence, discrimination) are higher in minority populations, the Collaborators do not know the entire extent to which mental health issues have impacted these populations. Part of this proposal will include a comprehensive epidemiologic survey to get a more concrete measurement of these numbers.

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<sup>24</sup> POLICYMAP, *supra* note xv.

<sup>25</sup> See *e.g.*, *Peoria County Mortality Report 2019*, *supra* note xiii, at 20.

#### **4. What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise? Are they expanding or narrowing? Does the proposal address root causes? If not, how could it?**

Historically, people of color have suffered various forms of structural oppression that has resulted in minority communities having less education, fewer job options, unsafe housing (and lack of access to the funds needed to rent or buy homes), more violence, lack of safe spaces to exercise, lack of grocery stores for nutritious food, and consistent discrimination. These foundational disparities create the obstacles that stand in the way of healthcare access (i.e. transportation, insurance coverage, financial resources for co-payments, time to attend appointments, ability to understand how to access and engage with providers, etc.).

While this proposal cannot address all these issues and eliminate the root cause of structural racism, it can develop and implement programs to remove the barriers that prevent equal access to quality behavioral and mental health care. This proposal will ensure that the community in which people of color live, work, and play, is able to become a healthier, happier place by providing adequate mental health resources for children and families.

## 5. What does the proposal seek to accomplish? Will it reduce disparities or discrimination?

The community conversations within the communities of color revealed the following are major barriers to seeking and getting mental health:

- Inherent stigma
- Lack of support services and peer support groups
- Lack of access to healthcare and difficulty navigating complex healthcare systems
- Lack of diversity in the healthcare providers who provide their care

This proposal has been designed to address the barriers that prevent children and families from seeking and obtaining behavioral health, mental health and substance use services in the Tri-County Area by developing and implementing programs and initiatives to ensure that the Collaborators can offer affordable, convenient, readily available and trusted services to the community. The proposal will bring increased and updated inpatient care to the area, add additional outpatient programs to avoid hospitalizations and will develop a safe and trusted space where the Collaborators will work collectively to streamline the logistical difficulties that frustrate patients and families and maximize the ability to identify and connect with more children and families in the community who need mental, behavioral or substance abuse services. The care and services contemplated are entirely patient-focused, patient-driven, and patient-centric.

The proposal will also:

- Expand and diversify the mental health workforce in Peoria
- Centralize the intake and support for children and families struggling with behavioral health issues through a coordinated care hub that includes a centralized, easily accessed physical space that can be reached by socioeconomically disadvantaged communities and
- Expand outreach to the schools to provide support for teachers and students to enhance resilience/compassion, raise awareness about mental health and decrease violence/bullying.
- Evaluate the outcomes of this work to determine what is most successful and endeavor to further those efforts while proposing changes to work that is less successful.

## 6. What are negative or unforeseen consequences and positive impacts/opportunities for equity as a result of this proposal? Which racial/ethnic groups could be harmed or could benefit? How could adverse impacts be prevented/minimized and equitable opportunities be maximized?

The Collaborators are confident that this proposal, if funded, will have a substantial positive impact on the Tri-County Area by accomplishing the goals outlined above. Furthermore, the Collaborators will continue to engage with the community conversations to help identify the impact that the interventions have on the community, and help implement an iterative process to respond to negative concerns or issues that are identified by the communities of color.



**7. What positive impacts on equity and inclusion, if any, could result from this proposal? Which racial/ethnic groups could benefit? Are there further ways to maximize equitable opportunities and impacts?**

One long-term goal of this proposal is to recruit and/or retain more skilled mental health providers of color to practice in the Tri-County Area. By developing a pipeline that includes internship programs, outreach to the schools, and ties between Bradley University, Methodist College and the University of Illinois College of Medicine Peoria, the Collaborators hope to engage the youth in these areas, show them career options, and ensure that they can access a path to these careers. The Steering Committee will also endeavor to identify strategies to reach out to and actively recruiting clinicians, therapists, and counselors of color. This could take many forms including active recruiting at historically African American colleges and universities or other similar strategies to grow and improve diversity among the Collaborators' personnel. This will, over the long run, promote racial equity among the mental health professionals in the area. Further, by having a welcoming, popular and convenient family health center accessible, it is possible that local business (stores/restaurants) would expand to the area and provide revitalization and economic growth to further benefit the area and its residents.

**8. Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion?**

As this proposal is focused on the mental and behavioral health needs of children and families in the Tri-County area, the Collaborative believes it has devised the most comprehensive and targeted plan to address the racial disparities that exist as it relates to this focus. There is additional work that can be done to further reduce racial disparities and advance racial equity and inclusion in the Tri-County Area, and it will take a multifaceted solution to end these disparities. By addressing one facet - the health and well-being of children and families - the Collaborative believes it will have a positive impact to improve the lives of its clients which will also improve other areas of the community such as education, and employment. With support from the state, including the funding being requested, these additional opportunities can be pursued with meaningful, positive impacts on racial equity and inclusion.

**9. Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement? Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability?**

When developing this proposal, the Collaborators were careful to identify and develop realistic, achievable, and sustainable programs and goals. With the engagement of the Center for Health Outcomes Research at the University of Illinois College of Medicine Peoria, the Collaborative will gather and monitor the data necessary to assess the program's efficacy in terms of goal achievement and improved outcomes.

**10. What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How will the level, diversity and quality of ongoing stakeholder engagement be assessed?**

The impacts of this project will be documented by the Center for Health Outcomes Research and through the work of an epidemiologist. First, the specific outcome measures will be identified. This will include but not be limited to outcomes such as: number of ED visits for mental health issues, outpatient follow-up utilization, number of clients seen at the new facility, number of clients receiving community based services, number of mental health providers in the area, diversity of the mental health workforce, number of days of school missed, number of bullying incidents, and many more. In addition to the quantitative assessment, qualitative assessments will be done to provide a complete, multi-methodological picture of the outcomes.

The plan will be to spend the first six months of the funding period collecting and analyzing baseline data. These will serve as the initial metrics to which all subsequent data will be compared. Once programs are being piloted and implemented, data will be collected and assessed every six months to determine how the data points are changing. This evaluation will be conducted over the life of the project, including after the transformation program and funding has expired, to determine the long-term impacts of this program on the community.

The results of these outcomes will be presented to the Collaborators on a regular basis and will be provided to community stakeholders. For those metrics where it appears there has been no improvement, the Collaborators will analyze the data and determine, based on the input from the Steering Committee, what needs to be implemented to improve those outcomes.

## 5. Community Input

### Service Area of the Proposed Intervention

**1. Identify your service area in general terms (e.g., “West Chicago”, “East St. Louis Metro Area”, “Southeastern Illinois”).**

The Tri-County Area, which includes Peoria, Tazewell, and Woodford counties, with specific focus on Peoria County and zip codes 61603, 61604, 61605.

**2. Please select all Illinois counties that are in your service area. (NOTE: Selecting a county does not mean that your intervention must service the entire county.)**

Peoria County, Tazewell County, and Woodford County.

**3. Please list all zip codes in your service area, separated by commas.**

Peoria County

61451, 61517, 61523, 61525, 61526, 61528, 61529, 61531, 61533, 61536, 61539, 61547, 61552, 61559, 61562, 61569, 61601, 61602, 61603, 61604, 61605, 61606, 61607, 61612, 61613, 61614, 61615, 61616, 61625, 61629, 61630, 61633, 61634, 61636, 61637, 61638, 61639, 61641, 61643, 61650, 61651, 61652, 61653, 61654, 61655, 61656.

Tazewell County

61534, 61535, 61546, 61550, 61554, 61555, 61558, 61564, 61568, 61571, 61610, 61611, 61635, 61721, 61733, 61734, 61747, 61755, 61759, 62682

Woodford County

61516, 61530, 61545, 61548, 61561, 61570, 61611, 61725, 61729, 61733, 61738, 61742, 61760, 61771.

### Community Input

**1. Describe the process you have followed to seek input from your community and what community needs it highlighted.**

The foundation for this collaborative is built on multiple community needs surveys with the Collaborators.

The University of Illinois College of Medicine Peoria Well-Being Taskforce convened key stakeholders from the medical and educational professional communities on six occasions between October 2019 and August 2020 to review the state of well-being in the medical community and to generate recommendations for various populations and settings. The taskforce identified many challenges, obstacles, and barriers for Peoria-area community members, but developed the following four general recommendations:

- 1. Consolidation of Resources:** Most represented areas are under-resourced and there is a notable difference in resource allocation across the different populations. In addition to adding support (see below), the Taskforce recommends the consolidation of resources when available. The creation of a centralized “warehouse” for empirically based resources would reduce both gaps and redundancies. The “warehouse” should be easily accessible to persons leading well-being efforts or who seek well-being resources such as educational presentations, workshops, trainings, counseling, therapy, medication management, and support services.
- 2. Uniform Screening Tools:** The Taskforce identified, across all populations, the need for better and greater well-being screening of the medical community. Some populations have no access to screening for well-being, whereas others are screened with non-empirically based measures or tools. Moreover, those who are screened sometimes do not have ready access to the resources needed to adequately address well-being deficits. The Taskforce recommends adoption of a uniform screening tool that can be employed by all persons in each population served. The tool should be empirically based, user friendly, and match deficits with resources to address them.
- 3. Evidence-based Programs:** The Taskforce also underscored the need for provision of evidence-based education and training programs that promote resilience, emotional awareness, and compassion and thereby prevent the onset of burnout, depression, and anxiety. Such skills will prove invaluable to all populations.
- 4. Increased Support.** Organizational and administrative leadership should formally support well-being efforts. Leader support should include promoting early access and engagement with well-being education, programming and services across the population represented. Leadership support underscores the value of skills that promote well-being for a successful career in the health fields, while bringing credence to existing skills-building training opportunities. Furthermore, research has shown that organizational and leadership support constitute the strongest predictor of effectiveness for workplace health and well-being initiatives.

As part of the Healthcare Collaborative, a group whose mission it is to improve racial equity around healthcare as mentioned above, UICOMP engaged key stakeholders from the most distressed areas of the community to develop and implement focus-groups to facilitate data-gathering and identify baseline metrics, obstacles and challenges that face the community, and particularly community members of color, related to their healthcare. Ten focus groups comprised of Black/African American and Hispanic/Latinx residents of zip codes 61603, 61604, and 61605 were developed and convened over a two-month period from June 2021 through July 2021.

These focus groups, providing opinions from 85 participants, illustrate that mental health care, for both adults and children, is of utmost concern to the community compared to the other health issues, such as cancer, discussed in the focus groups. Results also confirmed the need to focus on health literacy, improve access and resources particularly for mental healthcare, and enhance diversity among healthcare workers. Additional issues brought up by these groups also mentioned throughout this proposal include:

- The stigma around mental health/healthcare
- The need for providers who listen
- The long wait times for help
- The need for support groups
- The stress and trauma experienced regularly that contributes to mental health problems
- The lack of psychiatrists for children and the lack of resources in schools
- The lack of follow-up for patients released from the hospital
- The stress of being away from friends and family for immigrants to the US
- The anxiety about interactions with police
- The fear of being misled/mistrust in the system
- The frustration with resources in place not always being helpful

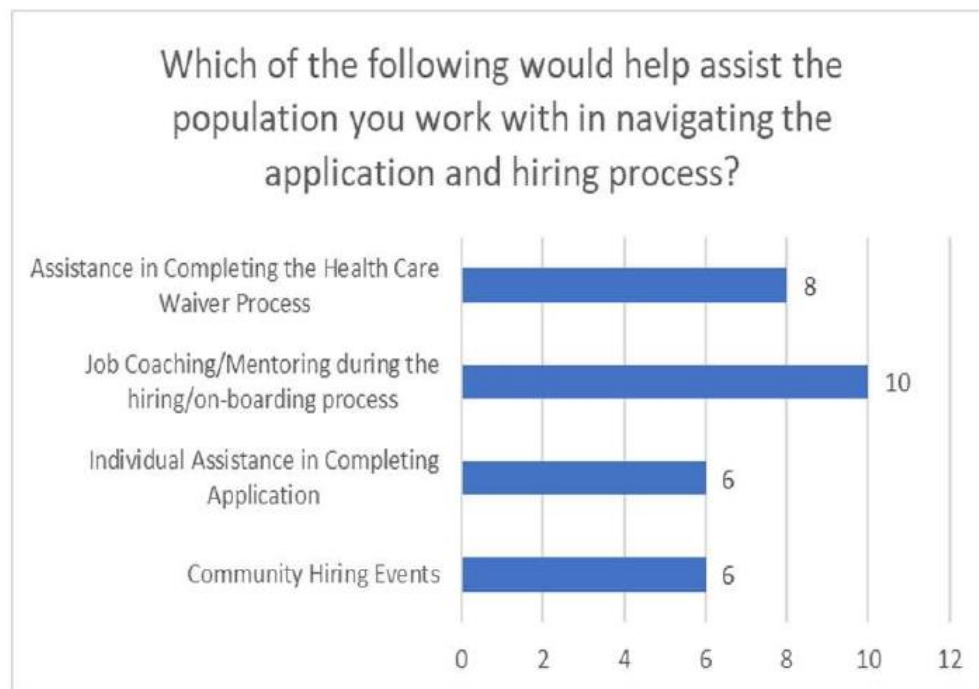
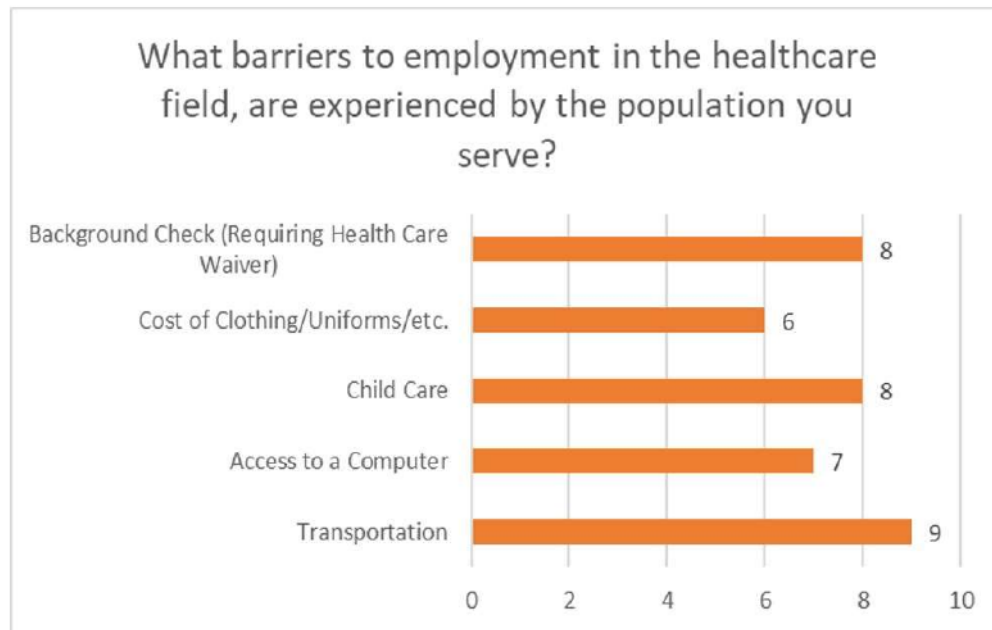
Additionally, UnityPlace convened its family community advisory board as well as the Greater Peoria Youth Mental Health Initiative Implementation Board to discuss the perceived barriers to accessing mental healthcare in the Tri-County Area. During these meetings, members shared the following concerns:

- Existing service providers are not able to provide enough services to meet needs.
- Most providers/agencies do not provide post-discharge aftercare education and support, ensure families are equipped to sustain healing, treatment, and progress.
- Youth are transferred to hospitals out of the area because of a lack of capacity.
- Some families are not aware of and/or do not access available services outside of school setting.
- Families and patients are concerned about the stigma associated with seeking healthcare.
- Families do not trust service providers.
- Wait times to enroll in services are too long and are frustrating.
- Service providers do not communicate with clients and families in way that is understandable.

UnityPoint Health has worked with community partners to identify barriers and facilitators to developing a large and representative workforce. In June 2021, feedback was solicited both in survey and then compiled and disseminated for an in-person discussion of responses. Partners from UnityPoint, Tri-County Urban League, Greater Peoria Economic Partnership, NAACP, Peoria Fair Employment Commission, New Millennium Institute, Peoria Public Schools, Living to Serve Foundation, County government, Goodwill, Advocates for Access and others identified the following community workforce development needs:

- Continued partnership for job placements and increased internship and apprenticeships
- Community hiring events
- Partnering with Local Community based organizations that provide workforce development and training and building a pipeline to employment with UnityPoint Health
- Communication with community agencies on jobs available and what the hiring process is.
- To be intentional with hiring efforts that target the under-served by becoming a stakeholder in those communities.
- Recruit directly from workforce development programs in the most distressed zip codes in Peoria County

The survey revealed that many qualified potential applicants felt that the cost of clothing, lack of childcare, lack of access to a computer and/or lack of transportation prevented them from seeking healthcare-related employment in the Peoria area.



Additionally, responses from this group provided the following directions to improve healthcare equities in Peoria:

- Share all information to other agencies in the community
- Continue educating at-risk populations on preventative health and vaccines

Based on the feedback from the community focus groups, this collaborative believes it has developed a proposal that responds directly to the concerns raised by the frustrated constituents in the target service area.

### **Input from Elected Officials**

#### **1. Did your collaborative consult elected officials as you developed your proposal?**

Yes.

#### **1A. If you consulted Illinois federal or state legislators, please select all legislators whom you consulted.**

Rep. Jehan Gordon-Booth  
Rep. Tom Demmer  
Sen. Dave Koehler  
Sen. Win Stoller  
Congressman Darrin LaHood  
Congresswoman Cheri Bustos

#### **1B. If you consulted local officials, please list their names and titles here.**

Peoria Mayor, Rita Ali, Ph. D  
Superintendent of Peoria Public Schools, Dr. Sharon Desmoulin-Kherat  
Peoria County Coroner, Jaime Harwood, BSN, RN, CFN  
Peoria Police Chief, Eric Echevarria



## 6. Data Support

### 1. Describe the data used to design your proposal and the methodology of collection.

This Collaborative relied heavily on the Community Health Needs Assessment (“CHNA”) that the Partnership for a Healthy Community conducted in 2019.<sup>26</sup> The Partnership for a Health Community is a community-driven partnership of public and private partners working together to address priority health issues in Peoria, Tazewell, and Woodford Counties. Members include county health departments, the Collaborators and other hospitals, healthcare providers and agencies. As a result of the 2019 CHNA, the Partnership identified four priorities for the Tri-County Area 2020-2022, one of which is Mental Health.<sup>27</sup> Additional qualitative data from the focus groups conducted by UICOMP, described above and attached hereto, were used. At all groups, notes were taken by medical students on everything that was said, and the notes were analyzed for themes to determine the most pressing issues raised within and across the groups.

Other Peoria-area studies published by the city and local health department also confirmed many statistics related to how unmet mental health needs is manifesting in the community in the form of suicide and violence.<sup>28</sup>

The collaborative also relied on its own internal utilization data to identify specific facts and figures regarding the services that are currently being offered, utilized, and delivered in the Service Area. For example, Methodist Medical Center was able to determine that more than 2,600 children and adolescents in need of inpatient behavioral health, mental health, or substance use treatment were either referred out of the community or did not receive treatment due to lack of capacity or a lack of resources to address the patients’ acuity. Other Collaborators provided their wait times and caseloads to confirm what gaps exist so that the Collaborators could determine how to overcome those statistics.

As described above in the “Healthcare Challenges” section, data from multiple sources were combined to assess the needs in this region.

It is important to acknowledge that the CDC Vulnerability Index has identified Peoria as a moderate to high level of vulnerability.<sup>29</sup> The target zip codes: 61603, 61604 and 61605 are among the most distressed in the nation.<sup>30</sup> Furthermore, the target zip codes all contain pockets where social vulnerability is ranked in the highest category for socioeconomic status, race/ethnicity, housing, and household composition/disability.<sup>31</sup>

Furthermore, the CHNA established distress in the area. In Peoria County, the Median income level is \$53,063<sup>32</sup>; which is far lower than the state average. The poverty rate for families in Peoria County was reported as 11.3%, which was substantially higher than the state average of 9.8%.<sup>33</sup> The unemployment rate in Peoria County has been higher than the state averages every year from 2013 - 2017.<sup>34</sup> In 2017, the poverty rate in Peoria County was 15.9%.<sup>35</sup>

The CHNA also established that Peoria County residents have significant mental health needs. When survey respondents were asked about their overall mental health, approximately 1/3 of respondents admitted they

experienced depression or stress in the last 30 days.<sup>36</sup> 8% of survey respondents described their mental health as "poor"; only 28% of respondents stated that their mental health was "good".<sup>37</sup>

Despite these admissions, there are insufficient mental health resources in the Peoria County Community to ensure residents are able to receive the mental health care they require. Of the respondents, 67% stated they have not talked to anyone about their mental health. Of those that did talk to someone about their mental health, 38% spoke with a doctor or nurse and 30% spoke to a counselor.<sup>38</sup>

The reasons for not seeking mental health care vary. 31% of survey respondents felt they could not afford the co-pay associated with mental health care; 27% did not seek care because of embarrassment or stigma; 11% had no transportation for care; 18% did not seek care because they lack insurance and 12% did not because their insurance was not accepted.<sup>39</sup>

These statistics are equally as troublesome for the area's youth. In the Tri-County Area, 31.3% of 10th grade students indicated that in the past 12 months they felt sadness or hopelessness almost every day for at least 2 weeks, causing them to stop participating in some of their usual activities. 16.7% of 10th graders indicated they seriously considered attempting suicide in the past 12 months.<sup>40</sup> Data from the 2018 Youth Survey measured illegal substance use among adolescents and found that Peoria County is at or above the state averages for substance use in all categories among 8th and 12th graders.<sup>41</sup> According to the National Institute of Mental Health ("NIMH") and National Alliance on Mental Illness ("NAMI"), delays in treatment contribute to the fact that 40% of students with mental illness drop out of high school.<sup>42</sup> Those same organizations have reported that suicide is the second leading cause of death in children ages 10-34 years.<sup>43</sup> There is increasing evidence that suicide rates among African American youth are rising. And the associated research emphasizes that the approach to reducing those suicide rates requires an emphasis on culturally competent care and addressing the community stigma and intolerance the youth face regarding mental health treatment and services.

These statistics are consistent with troubling school performance. Peoria High School and Manual Academy also have the lowest graduation rates, at 64% and 62%, respectively.<sup>44</sup> (The State average is 85%). In Peoria HS (serving zip code 61604), 40% of students were chronically truant. In Manual Academy (serving zip code 61605), 26.8% of students were chronically truant.<sup>45</sup> This is significant because the cause of truancy among high-school students is most likely the result of inappropriate behavior and poor decision-making by the individual students.<sup>46</sup> High truancy rates leave children unable to achieve their full potential, which only exacerbates cultural, racial, and socioeconomic disparities.

The Peoria-area schools have been described as having the most segregated public schools of any metropolitan area in the nation.<sup>47</sup> Peoria also has a high crime and murder rate. The crime rate in Peoria in 2019 was 1.8 times the national average. Peoria has been ranked 15<sup>th</sup> in the nation for its murder rate, which is increasing.<sup>48 49</sup> From 2017 to 2019, the murder rate doubled. Homicide deaths also impact persons of color disproportionately.<sup>50</sup> The two leading causes of death for persons age 15-24 in Peoria County are homicide (52.9%) and suicide (11.8%).<sup>51</sup>

For those that do seek treatment, there are insufficient resources to meet needs.

Methodist Medical Center of Illinois opened Peoria's very first inpatient mental health unit in 1954. Today, as the only inpatient provider for kids in Central Illinois, Methodist Medical Center's child AMI unit is routinely at maximum capacity. And even when the unit is not at capacity, many children cannot be treated at Methodist Medical Center of Illinois because the outdated unit is not equipped to ensure safety for children who display physical aggression and need to be isolated. Specifically, in 2019 and 2020, there were 582 and 598 children and adolescents, respectively, who were referred to other hospitals for inpatient services because Methodist Medical Center of Illinois did not have the capacity or capability to treat them close to home. So far during 2021, 484 children and adolescents have been denied inpatient admission at Methodist Medical Center for the same reasons. Because there are no other inpatient options in the area, patients are forced to seek treatment and get help hours away from home separated from their family in an unfamiliar place. This Collaborative and its proposal will address these capacity and capability issues and provide an updated, modernized space that complies with all current safety requirements while also eliminating an "institutional" feel that exists today. This upgrade will foster a more familiar and healthier continuum of care setting with the added benefits of more integrated, available outpatient services, increased familial education, and amenities designed to reduce barriers and facilitate engagement.

When making referrals for psychiatric evaluation or treatment, Collaborators' clients are often told the area psychiatrists are not taking new referrals; for those psychiatrists that are taking new patients, the waiting list is more than one (1) year. Furthermore, some area psychiatrists do not accept Medicaid coverage. Heartland Health Services (a collaborator) provides services to low- and no-income families and has a much shorter wait time to see a psychiatrist. But, because Heartland Health Services is a Federally Qualified Health Center ("FQHC"), regulations require the patient to transfer their primary care to Heartland and follow one of Heartland's primary care providers to receive and retain the psychiatric referral. Based on the focus group research, families want to be able to see a specialist in a reasonable amount of time without having to change the primary care provider they have come to trust.

For Children's Home (a Collaborator), there is an eight to twelve-month waitlist for a child-client to be seen for in-home therapy because each therapist is carrying a caseload of 13-19 cases across the entire Tri-County area. Children's Home is also averaging 30 pre-admission psychiatric screenings per week on its CARES line.

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<sup>26</sup> CHNA, *supra* note ii at 22.

<sup>27</sup> Partnership for a Healthy Community, *1/1/2020-12/31/2022 Priority Mental Health*, (last accessed Nov. 15, 2021), <https://healthyhoi.org/2020-22-Mental-Health>.

<sup>28</sup> See *Peoria County Mortality Report 2019* *supra* note xiii.

<sup>29</sup> *Social Vulnerability Index*, *supra* note i.

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*

<sup>32</sup> CHNA, *supra* note ii at 21.

<sup>33</sup> *Id.* at 22-23.

<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

<sup>36</sup> *Id.* at 50.

<sup>37</sup> *Id.* at 49.

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<sup>38</sup> CHNA, supra note ii at 48.

<sup>39</sup> *Id.* at 34.

<sup>40</sup> *Id.* at 81.

<sup>41</sup> *Id.* at 51, 57.

<sup>42</sup> *23<sup>rd</sup> Annual Report to Congress* supra note xviii.

<sup>43</sup> NAMI, supra note ix.

<sup>44</sup> CHNA, supra note ii at 23-24, 26 (*citing* Illinois Report Card, <https://www.illinoisreportcard.com/School.aspx?schoolid=480721500250024>).

<sup>45</sup> *Id.*

<sup>46</sup> *Id.* at 23-24.

<sup>47</sup> Vock, D.C. and Maciag, M., supra note x.

<sup>48</sup> Fieldstadt, E., supra note xi.

<sup>49</sup> *Crime Rate in Peoria, IL*, supra note xii.

<sup>50</sup> *Peoria County Mortality Report 2019*, supra note xiii, at 21.

<sup>51</sup> *Id.* at 10.

## 7. Health Equity and Outcomes

### 1. Name the specific healthcare disparities you are targeting in your service area, including by race and ethnicity. Describe the causes of these disparities that your project specifically seeks to address and explain why you have chosen to address these causes.

Mental health can be impacted by a variety of factors, most of which are out of one's control. One main trigger for a mental health crisis is stress, and stress disproportionately affects populations of color who, in Peoria, tend to be poor, live in areas where more violence happens, have food insecurity, and have been more impacted by COVID-19. These social determinants of health serve as markers of stress in a community and absent the resources needed to mitigate them, the effect can transcend generations. This spiral of stress eventually funnels to affect young children the most because they have not developed mature coping skills and are often unable to access the help they need. These disparities and the impact on racial minorities have been confirmed in the Community Health Needs Assessment for the Tri-County Area.

At Methodist Medical Center, 15.9% (or 200 of 1,257) of the child/adolescent behavioral health admissions involve a patient from one of the three target zip codes. Of those 200 patients from the three target zip codes, 55.5% (111 of 200) are members of a minority (Hispanic/Latino, Black/African American, Multiracial). At the Mental Health Clinic, 27.4% (or 114 of 416) of the treated minors reside in one of the three target zip codes. Of those 114 minor patients, 44.7% are minorities. And for Emergency Department visits, 25% (or 266 of 1066) of the minors presenting for behavioral health related issues are patients from one of the three target zip codes. Of those 266 minor patients, 51.5% were minorities.

Although behavioral health, mental health and substance use disorders do not favor or discriminate against particular races, minorities will experience greater obstacles and barriers to treatment because of various factors, including environmental factors, access to behavioral health and mental health services, cultural stigma, systemic racism. In Peoria, unemployment, poverty, a small provider pool and an even smaller provider pool that accepts Medicaid coverage only contributes to the underlying disparities that disadvantage persons of color.

The focus groups that were led by the Collaborators confirmed that Peoria-area persons of color believe improved mental health must be a top priority for the region.

Given this, and the known lack of providers in the area, particularly those that serve the Medicaid-covered population, and the negative long-term effects of unaddressed mental health issues, this Collaborative believes that coordinated services and increased coverage will be extremely beneficial to the Community, and its residents of color.

### 2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

To address these disparities and increase access to child and adolescent mental health and substance use disorder services, the Collaborative will coordinate among the involved agencies to:

- Increase the number of available counselors, therapists, psychiatrists, and other providers to increase access and decrease wait times for services
- Ensure all additional counselors, therapists and other providers that are hired as part of The YFBHC accept Medicaid coverage
- Design and build a coordinated treatment and community center, the Hub, that will provide the entire spectrum of services addressing child and adolescent behavioral health in a convenient, local community center within the target zip codes
- Ensure transportation and day care services are available so that families are not prohibited from taking a child to an appointment or service because they cannot access or afford transportation or childcare
- Hire and train Family Navigators to address insurance issues, arrange for convenient, stacked appointments to minimize parents' time away from work and other obligations
- Develop and implement a shared assessment to be used among providers and offered to pediatricians/primary care providers to facilitate early diagnosis and intervention
- Develop a shared service plan that addresses social determinants of health to ensure the patient and family have adequate and appropriate food, shelter, transportation, support, and safety to succeed in their treatment plan and avoid further trauma and crisis
- Recruit staff, navigators, counselors, therapists, and clinical professionals of color who will serve low-income families and foster patient comfort and trust

Once operational, the Collaborative will measure how many individuals are being served in the various settings and the impact those services are having on various outcomes. The Collaborative will measure how many times an individual has accessed a single touch point, patient satisfaction, and how many organizations are coordinating care or referring clients to this coordinated care hub. Additionally, a cost analysis will be done to determine the overall financial benefit of this coordinated care model.

The goal of engaging with the schools and community will allow agencies to meet individuals where they are. School outreach will provide services to larger groups of children and teachers, training them to be more resilient and tolerant. This school-based program will also encourage discussions about mental health to reduce stigma. The impacts of these community care models can be measured by the number of ED visits related to behavioral/mental health, the number of suicides and attempts, the number documented bullying/fighting incidents at a given school, as well as truancy rates.

Our long-term goal is to get more providers, including providers of color, to work in Peoria and serve our community. The Steering Committee will develop strategies to actively recruit clinicians, therapists, and counselors of color. This could take many forms including active recruiting at historically African American colleges and universities or other similar strategies to grow and improve diversity among the Collaborators' personnel. Furthermore, through its workforce development program, the Collaborators have been and will continue to reach out to communities of color to provide resources and assistance to pursue jobs and careers in the healthcare field. As the Collaborative takes shape, it will monitor the workforce and identify who is practicing in the area, who is accepting Medicaid, and how the racial/ethnic make-up of this population is

changing. Diversity will not be achieved immediately; however, after many years of increasing the number of providers through added fellowship programs, internship programs, and opportunities for persons and students of color to advance, this will have a broad impact for the community where people will no longer have to wait for appointments, where the healthcare workforce looks more like the community being served and where people will have a choice in therapist so they can best find someone who is able to help them/their families in a mental health crisis or on a regular basis.

### 3. Why will the activities you propose lead to the impact you intend to have?

This Collaborative and its proposal are entirely patient-centric. By refocusing our efforts on why patients and families cannot or do not seek care for follow-through on care, and eliminating the causes of those frustrations, fears and obstacles, this vulnerable population will be brought closer to equal access to mental health, behavioral health and substance use disorder treatment.

The development of this Collaborative has brought critical services together and initiated a dialogue that is focused on improving the delivery of care and services to the Tri-County Area by removing barriers and improving impact. These meetings have given the Collaborators opportunities to learn more about each other and how they can connect their clients and patients into other Collaborators' programs. By fully funding and operationalizing this program, the Collaborators will be able to train the Family Navigators to make the same connections for patients and families on a consistent basis. The improved and enhanced coordination among the Collaborators will translate into greater coordination in the Community. Coordination of care will save families time, frustration, money and travel, which, although it is not enough to raise someone out of poverty, will hopefully help parents miss fewer hours of work and have more time available to tend to other needs. Having a central location where providers can coordinate and patients can access all the services and resources they require, this Collaborative will take an overwhelming care model and deliver a more integrated, efficient, and understandable program. By reaching out to the schools and into the community, the Collaborators will be able to provide services where they are needed, without burdening individuals with finding transportation to various locations. This will also save parents time and money, which would substantially help our vulnerable populations. This will allow the Collaborators to address the needs of a child/family holistically, which has the potential to substantially improve the quality of life and improve the community at large.

Finally, by increasing the number of providers and providers of color, this will not only decrease waiting times for appointments, but it will also increase the number of practices in town, which will increase the odds that a service, a therapist or other unmet need will be more easily accessible. By diversifying our workforce, the Collaborative will meet the needs of the community that want to see more providers who "look like them" and who "speak the same language." By hearing this concern and addressing it through a professional pipeline program, the Collaborative will ensure that not only are there providers who are available to take new patients, but that some of these providers will be of color, which can in some cases instantly increase trust and understanding between patient and provider.

By helping Peoria's youth achieve improved mental and physical health, the Community will see improved school performance, which lends to a more successful workforce. This, in turn, will improve the economy,



which will further improve healthcare access and opportunities and make further inroads in the systemic inequities that exist all around the Tri-County area, but especially in Peoria area zip codes 61603, 61604 and 61605.

## 8. Access to Care

**1. Name the specific obstacles or barriers to healthcare access you are targeting in your service area. Describe the causes of these obstacles that your project specifically seeks to address and explain why you have chosen to address these causes.**

The CHNA clearly defines and describes the issues and obstacles that Peoria-area families experience with access. Regardless of need, the area's children are unable to receive necessary services because there are not enough providers that accept their insurance, because of long wait times for appointments, because of a lack of transportation, and because the patients and families are concerned about the stigma associated with mental health and behavioral health treatment.

Another obstacle to care is the lack of a coherent system of intake and follow-up for children and adolescents in need of mental health care. This lack of cohesion can send families bouncing from one agency to another, doing similar intakes after long waits, and getting discouraged and sometimes giving up before their needs have even begun to be met. This is not acceptable, particularly given the vast needs of this community that have only become more apparent and exacerbated during the pandemic.

**2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?**

This Collaborative's proposal will increase access to care in Peoria by:

- Increasing the number of available inpatient beds in the area from 23 to at least 43 beds
- Creating the region's first and only behavioral health ICU so that the highest acuity children and adolescents do not need to be transferred more than 75 miles away to Springfield or Rock Island.
- Increasing the number of psychiatrists and counselors available to serve Medicaid beneficiaries, thereby reducing wait times for appointments
- Establishing the first unit specializing in the care of children with Autism and Asperger's
- Developing an intensive outpatient program to reduce inpatient admissions
- Creating a 24/7 crisis center to provide intervention services to families and avoid unnecessary Emergency Department visits
- Bring all local services into a central, local, convenient location where families can all receive treatment, support, and social services
- Utilize Family Navigators to streamline and stack appointments to minimize disruption and time away from school, work, and other obligations
- Provide transportation and day care services so no family must cancel an appointment because they cannot obtain or afford these necessary services
- Hire and train Family Navigators to address insurance issues, arrange for convenient, stacked appointments to minimize parents' time away from work and other obligations
- Build a pathway to increase the number of qualified providers that are committed to serving low-income patients and families
- Ensure all services provided under The YFBHC are covered by Medicaid

- Bring these services into the most vulnerable neighborhoods to foster trust and comfort for those disenfranchised by “the system.”

### 3. Why will the activities you propose lead to the impact you intend to have?

The YFBHC came together to find the root causes related to healthcare access in the community and worked together to develop realistic, transformational plans to eliminate barriers and obstacles for accessing care.

Implementing coordinated shared tools from a centralized location will improve care coordination and reduce inefficiencies and redundancies that plague the existing “system” and consume providers’ valuable time and resources. By reducing these inefficiencies and creating more capacity to deliver effective services, this Collaborative will increase access to care by ensuring that individuals are maximizing their time with the right providers who have the right information in the most conducive setting – the Hub, a school or in the patient’s home.

By increasing the number of providers, including providers of color, waiting times for appointments will be decreased, and more children will be able to be seen when they need care. Currently, individuals from wealthy families can see private therapists, while socioeconomically disadvantaged individuals do not have this luxury and are often waiting for weeks to months for appointments with the limited number of providers who may take Medicaid. Changing these numbers and specifically encouraging new practitioners to serve the underserved populations will ensure that everyone has access to care when it is most needed. Although not part of this proposal, one ideal goal is to incentivize serving those in need.

## 9. Social Determinants of Health

### 1. Name the specific social determinants of health you are targeting in your service area. Describe the causes of these social determinants that your project specifically seeks to address and explain why you have chosen to address these causes.

This Collaborative serves patients and families every day that must confront and overcome multiple social determinants of health. Unique to child and adolescent behavioral health is the fact that patients in crisis are often part of a family in crisis. It is not enough to assume a family can make and keep healthcare appointments for a child. Unfortunately, a child's behavioral health needs may be given a lower priority when income, food, housing, and safety are unstable. Addressing social determinants of health ("SDOH") is foundational to ensuring a child can obtain and follow-through on a service plan and is critical to ensuring the patient's family can support the child on their healing journey. The YFBHC will work to ensure there are available services in the community, based out of the family center and coordinated care hub, to provide food bank and nutrition services, primary care, therapy services, substance abuse services, parent training/education, suicide prevention and awareness services, LGBTQ+ supports, exercise classes, support groups, and other services identified by the YFBHC governance during the course of the project.

### 2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

The YFBHC will address the social determinants in many ways.

At the center is the Family Navigators and the shared service plan. For those children and families in crisis, the navigator will be trained to identify SDOH and connect the patient and family to those necessary resources to ensure the child and family can work towards ensuring adequate income, food security, safety and housing.

The Collaborators all provide a broad range of clinical and social services that can address a family's SDOH needs regardless of severity. The shared service plan will include these SDOH so that the treatment team – whether it be one provider or more – can be mindful of these issues and incorporate these SDOH in a whole-person, whole-family approach to the child's care.

The delivery of SDOH services will be monitored by the Collaborative by the Center for Health Outcomes Research and through the work of an epidemiologist. In addition to other metrics, this collaboration will be identifying and analyzing data and outcomes related to the number of clients receiving community-based services, including the type. This will allow the Collaborative to monitor how they are impacting SDOH and what other services may need to be incorporated more fully.

### 3. Why will the activities you propose lead to the impact you intend to have?

For a patient or family to be engaged in treatment and progress towards sustained healing, they must be able to commit to the service plan without experiencing further trauma. By establishing a point of contact, the

Family Navigator, who can facilitate services and resources to provide stability and support, the patient and family can avoid further trauma and remain focused on continuing the necessary treatment that will only enhance their collective ability achieve, grow and succeed.

When everyone, regardless of skin color, has access to a mental health provider when they need it, and when they can be seen promptly, and when they can receive care in a convenient, accessible setting, the Community will improve with healthier, happier, thriving children and families. By using this three-pronged approach of coordinating/centralizing care, conducting more outreach in the schools, and creating a pipeline to increase diverse mental health practitioners, this Collaborative will ensure that the burdens of lack of access to care, lack of access to education, and the lack of a supportive social/community environment, will be eased in the Tri-County Area.

## 10. Care Integration and Coordination

### 1. Describe how your proposal improves the integration, efficiency, and coordination of care across provider types and levels of care.

All providers, including these Collaborators, can agree that siloed and fragmented care reduces quality, increases costs and results in poor outcomes. This proposal, a true collaborative, brings together social and clinical providers to serve patients “under one roof” in a model that will share assessments and service plans so that each individual provider can deliver their specific service with an understanding and appreciation for the other services that the patient is receiving. This model that connects the Collaborators will ensure the rights services, in the right place, at the right time for the patient and their family.

Furthermore, by collectively adopting an evidence-based practice, patients’ providers will speak the same language, use similar techniques, and focus on similar goals. As a patient and family transitions between services and treatments as they progress to lower acuity services, that shared evidence-based practice will provide consistent tools and strategies that the patient and family can internalize and use up to and beyond their graduation from the Collaborators’ services. That consistency through a coordinated approach will provide an improved patient experience, which will only foster increased engagement.

These Collaborators have come together to work closely to break down barriers and reform the way they can deliver care. Knowing they can work closely to re-envision how they deliver care. The Collaborators are confident and motivated to operationalize these transformative ideas and continue to work closely together for the benefit of individual patients and their families.

### 2. Do you plan to hire community health workers or care coordinators as part of your intervention?

Yes.

#### 2A. Please submit care coordination caseload numbers and cost per caseload (stratified by risk, if applicable).

Care Coordination will be provided by the Family Navigators. Based on estimates from collaborators’ care coordination experience, and average caseload of 20 Collaborative-defined eligible families/navigator will be maintained. For families with high acuity needs, a caseload of 12 Collaborative-defined eligible families/navigator will be maintained. Duration of Family Navigator involvement will depend on specific family needs, in combination with the Collaborations’ pending definition of care coordination graduation. Family Navigators will be hired in year 1 of funding at an initial annual rate of \$48,713, indicating an average cost per caseload of \$2,435 for most families and \$4,059 for those with higher acuity needs.

These estimates are based on Family Navigator involvement for a full year. However, it is expected that as Collaborators establish organizational integrated practices, families will feel empowered, informed, and knowledgeable to graduate from the care coordination program in a shorter amount of time.

**3. Are there any managed care organizations in your collaborative?**

No

**3A. Please list the names of the managed care organizations in your collaborative.**

N/A.

**3A. If no, do you plan to integrate and work with managed care organizations?**

Yes

**3B. Please describe your collaborative's plans to work with managed care organizations.**

All Collaborators that are eligible for certification with Medicaid provide covered services and serve managed care members currently. As this collaborative is committed to expanding covered services, the Collaborative will continue to work with Managed Care Organizations to ensure its members are provided increased access to quality, covered services.



## 11. Minority Participation

**1. Please provide a list of entities that will be a part of your collaboration/partnership that are certified by the Illinois Business Enterprise Program (BEP) and/or not-for-profit entities majorly controlled and managed by minorities that will be used on the project as subcontractors or equity partners.**

Tri-County Urban League, a Collaborator, is a not-for-profit entity majorly controlled/managed by minorities.

The Hult Center for Healthy Living, a Collaborator, is led by an African American female.

The University of Illinois College of Medicine – Peoria, a Collaborator, is managed by a minority Interim Dean.

When possible, the YFBHC will solicit proposals from small and minority businesses, and women owned businesses. The following steps will be followed to ensure these types of business enterprises are used when possible:

- Place qualified small and minority businesses, and women's business enterprises on solicitation lists, and ensure they are solicited whenever they are potential sources.
- When feasible, divide purchases into smaller quantities to permit participation by these business enterprises.
- When feasible, allow for delivery schedules that allow for participation by small and minority businesses, and women's business enterprises.
- Appropriately use the services of organizations such as the Small Business Administration, and the Minority Business Development Agency.
- Require similar action steps for prime vendors in their selection of sub-contractors when applicable.

The University of Illinois adheres to a Supplier Diversity Program and works with only BEP certified vendors and will extend that commitment into this collaborative.

**2. Please describe the respective role of each of the entities listed above, and specify whether they will have a role only during the implementation of your proposal or if they will have a role in the ongoing operation of your transformed delivery system.**

Both Tri-County Urban League and the University of Illinois College of Medicine Peoria are Collaborators in this project. As Collaborators they will participate in the governance structure that develops the programming and services described in and throughout this proposal as well as monitor for goal achievement. Additionally, the University of Illinois College of Medicine Peoria will provide substantial support with data aggregation and outcome measurement for purposes of reporting results to HFS.

## 12. Jobs

### Existing Employees

**1. For collaborating providers, please provide data on the number of existing employees delineated by job category, including the zip codes of the employees' residence and benchmarks for the continued maintenance and improvement of these job levels.**

YFBHC Proposal – Section 12. Jobs – Existing employees by category and zip code

### New Employment Opportunities

**2. Please estimate the number of new employees that will be hired over the duration of your proposal.**

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**3. Describe any new employment opportunities in the future alignment of your proposal and how those opportunities reflect the community you serve.**

Throughout 2021, Collaborators launched a community partner survey to understand and explore the barriers to healthcare-related employment that exist in the area and what steps can be taken to assist the respondents with applying for healthcare related jobs in the Service Area and what can be done to make the hiring process more inclusive.

The survey revealed that many qualified potential applicants felt that the cost of clothing, lack of childcare, lack of access to a computer and/or lack of transportation prevented them from seeking healthcare-related employment in the Peoria area.

Job coaching, mentoring and assistance with the processes associated with hiring were identified as the most helpful resource that could assist with employment.

Furthermore, the respondents communicated that they would be more inclined to pursue healthcare-related employment if they were exposed to more information about the positions, the process the benefits and the accessibility. For example, most of the Hispanic families in Peoria are immigrants with first-generation children who seek employment based on what they and their peers in the community see and know. There are opportunities to develop a more diverse and inclusive workforce by partnering with local community-based organizations – like those in this collaborative – to provide workforce development and training and building a pipeline to employment in the healthcare industry. The focus group also identified that informational videos are highly effective in communicating information (in multiple language) to a diverse audience. The videos can address opportunities but also provide answers to the questions potential applicants have related to benefits, costs, time, transportation, schedules, immigration concerns and the like. By sharing more information and allaying concerns, more persons of color from different backgrounds can find a path to employment in healthcare and with the Collaborators here.

This collaborative plans to hold hiring events in specific communities, providing language interpreters to connect with a more diverse workforce and provide a more communicative application process, including feedback when a position is not offered, will foster comfort among persons and cultures who would typically not consider employment with a healthcare provider or in the healthcare field.

#### Child and Adolescent Inpatient Center

- 7.0 FTE RNs
- 3.0 FTE Masters Level Clinicians
- 4.0 FTE Child Psychiatrist
- 17.5 FTE MHAs or CMAs
- 4.8 FTE program assistants or CNAs
- 1.0 FTE Recreational therapist
- 7.4 FTE Security
- 0.5 FTE Chaplain
- 12.0 FTE Kitchen
- 4.6 FTE EVS
- 0.5 FTE Nutritionist

#### Methodist Medical Center – Outpatient Staffing

- 1.8 RN
- 3.0 MOA
- 3.0 Master Level Clinicians

#### Community Outreach

- 5.0 FTE Family Navigators

In-School Health (LCPC or LCSW 3 Peoria SBHC, East Peoria, Pekin, Support adolescent behavioral health initiative (Center for Wellbeing teacher and student training and education)

- 1 APN for East Peoria SBHC
- 1 APN for Pekin SBHC
- 1 CMA for East Peoria SBHC
- 1 CMA for Pekin SBHC
- 6 LCPC/LCSW for PPS

#### Child and Adolescent Psychiatry Fellowship

- 2 Double-Board Certified CA psychiatrists
- 1 Program Coordinator
- 2 Child and Adolescent Fellows/year for two years (years 4-5)

#### Outcome measurement

- 0.2 FTE for director of the Center for Health Outcomes Research (MD or PhD)

- 0.25 FTE for statistician (PhD)
- 0.5 FTE for research assistant (BA/BS)

#### Collaborative Administration

- 1.0 FTE Collaborative Coordinator

#### 4. Please describe any planned activities for workforce development in the project.

The Collaborative plans to develop materials and videos to reach into the community share the opportunities that exist. The Collaborative will hold hiring events in specific communities, providing language interpreters to connect with a more diverse workforce and provide a more communicative application process, including feedback when a position is not offered, will foster comfort among persons and cultures who would typically not consider employment with a healthcare provider or in the healthcare field.

The YFBHC will also support the development of a child and adolescent psychiatry fellowship. A new YFBHC's child and adolescent psychiatry fellowship will be an attractive recruitment vehicle for adding the requisite UICOMP faculty members, while adding service through relatively low-cost trainees. Most important, the creation of a fellowship program will serve as a pipeline for recruitment of graduate trainees. Trainees interested in this field will have the opportunity to continue their training and forge professional relationships in their local community, thereby increasing the probability that these homegrown physicians will remain in in the Tri-County area.

### 13. Quality Metrics

#### Alignment with HFS Quality Pillars

##### 1. Tell us how your proposal aligns with the pillars and the overall vision for improvement in the Department's Quality Strategy.

The YFBHC aligns with three (3) of the five HFS Quality Pillars: Child Behavioral Health, Equity, and Improving Community Placement.

This proposal incorporates and operationalizes all of HFS' vision to improve behavioral health services and supports for children. This proposal will improve integration of physical and behavioral health by aligning and involving social and clinical supports in a shared service plan with the assistance of a family navigator to aide patients and families in utilizing the available services and supports available. The proposal will also improve transitions of care from inpatient to community-based services by developing the central, convenient, comfortable inpatient and outpatient community center. Bringing inpatient, outpatient, and social services under one roof will increase alignment and assist families in coordinated, smooth transitions between levels of acuity and service. Additionally, the proposal will develop and grow services designed to reduce hospitalizations and provide high-acuity and crisis interventions without having to send a patient to the emergency department.

The proposal aligns with the HFS goal of serving more people in the setting of their choice, and through the hub and spoke model there will be both centralized and expanded care, covering all locations including schools, in-home services and other community-based services and supports.

The use of evidence-based practice to coordinate care and centralize intakes, will serve as a model to attract new providers and create a state-of-the-art program, better than any in the region, for the benefit of a community in a high-vulnerability area.

##### 2. Does your proposal align with any of the following Pillars of Improvement?

###### 2A. Maternal and Child Health?

No

**Maternal and Child Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.**

N/A

###### 2B. Adult Behavioral Health?

No

**Adult Behavioral Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.**

N/A

## **2C. Child Behavioral Health?**

Yes

**Child Behavioral Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.**

1. Outpatient follow-up after behavioral health hospitalization or ED visit at 7-days and 30-days
2. Crisis response services that result in hospitalization
3. Visits to ED for behavioral health services that result in hospitalization
4. Overall number and length of behavioral health hospitalizations
5. Number of repeat behavioral health hospitalizations

## **2D. Equity?**

Yes.

**Equity: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.**

1. Reduced hospitalizations among minorities in target zip codes
2. Reduced inpatient transfers to hospitals outside the service area
3. Increased utilization of Medicaid-covered behavioral health, mental health and substance use services in the target zip codes

## **2E. Community-Based Services and Supports?**

Yes.

**Community-Based Services and Supports: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.**

1. Increased utilization of Medicaid-covered behavioral health, mental health, and substance use services in community-based settings (i.e. school and in-home care)
2. Number of mobile crisis response screenings
3. Reduction in re-admissions

### 3. Will you be using any metrics not found in the quality strategy?

Yes.

#### 3A. Please propose metrics you'll be accountable for improving and a method for tracking these metrics.

1. Reduced DCFS referrals
2. Reduced suspensions/expulsions for schools



## 14. Milestones

- Family Navigator Program
  - Months 1-5: Develop program metrics and benchmarks (Months 1-5)
  - Months 6-9: Recruit Family Navigators (Months 6-9)
  - Months 9-12: Train Family Navigators (Months 9-12) *\*to coincide with shared assessment being completed*
  - Beginning Month 12: Implementation of Family Navigator Program
- Shared Practice Tools
  - Months 1-3: Purchase evidence-based practice
  - Months 4-6: Train personnel on evidence-based practice
  - Months 7-10: Develop shared assessment tool
  - Months 9-12: Develop shared service plan
  - Beginning Month 12: Implementation of evidence-based practices and shared tools
- Internships
  - Months 1-6: Planning (identify positions and quantity)
  - Months 4-12: Recruiting
  - Beginning month 10: Implementation of interns
- Fellowship Program
  - Months 1-12: Recruit core faculty, develop fellowship program and apply for accreditation
  - Months 13-16: Waiting period for approved accreditation
  - September 1 following receipt of accreditation: Fellowship recruitment begins (Fellowships follow a standard annual cycle will recruiting occurring from September – January each year. Fellows are selected in January and the Fellowship begins on July 1 each year).
- Program Evaluation
  - Months 1-6: Baseline data collection
  - Months 6-9: Baseline data analysis
  - Months 10-12: Baseline results reporting
  - Months 13-14: Data acquisition begins
  - Months 15-16: Data analysis begins
  - Months 17-18: Dissemination, discussion and review of data begins
  - The evaluation process will be repeated every six months
- Family Hub and Community Center
  - Months 1-3: Purchasing/Closing on property
  - Months 2-5: Design
  - Months 5-7: Bids
  - Months 5-9: Permits
  - Months 9-23: Construction

- Months 22-24: Licensure, Certifications, Occupancy and other Approvals
- Month 25: Opening of Hub and Community Center.

| Youth and Family Behavioral Health Collaborative - Timeline and Milestones                                |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|---|------------|-----------------------|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|   | Post-Award | Funding Months 1 - 25 |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|   | 0          | 1                     | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| Steering Committee  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Develop Steering Committee Members  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Prepare/execute Affiliation Agreement   |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Steering Committee Initial Meeting  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Charter Development   |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Family Navigators   |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Develop program metrics and benchmarks  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Recruit Family Navigators   |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Train Family Navigators   |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Implement Family Navigator Program  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Shared practice tools   |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Purchase Evidence-Based Practice ("EBP")  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Train Personnel on EBP  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Develop shared assessment   |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Develop shared service plan   |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Implement EBP and shared tools  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Internships   |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Planning (Identify positions/number)  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Recruiting  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Services provided   |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Fellowship  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Recruiting core faculty   |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Planning  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Waiting for accreditation   |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Fellowship Recruiting (*per annual cycle)   |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Fellowship Program Initiates (*per annual cycle)  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Beginning September 1 after accreditation received.<br>Eight months after recruiting, which is on July 1. |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Program Evaluation  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Baseline data collection  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Baseline data analysis  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Baseline results reporting  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Data acquisition  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Data analysis   |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Dissemination/Discussion/Review   |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Hub   |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Purchasing/Closing  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Design  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Bids  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Permits   |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Construction  |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Licensure/Approvals   |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Operational   |            |                       |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

*\*This chart has been also been attached to this proposal as a separate exhibit.*

## 15. Budget

### 1. Annual Budgets across the Proposal

### 2. Number of Individuals Served

Please project the number of individuals that will be served in each year of funding.

#### Year 1 Individuals Served

2100

#### Year 2 Individuals Served

2250

#### Year 3 Individuals Served

2700

#### Year 4 Individuals Served

2700

#### Year 5 Individuals Served

2700

#### Year 6 Individuals Served

2700

### 3. Alternative Payment Methodologies

No alternative payment methodologies have been identified at this time. The collaborative, however, is willing to work with managed care organizations to develop strategies and programming to maximize the project goals and would be open to possible alternatives.

## 16. Sustainability

The YFBHC is requesting transformation funds to build out the spaces and systems that will allow the existing Medicaid-certified providers to continue to deliver care and services that are covered by their existing relationships with Managed Care Organizations and other payors. Although the initial investment in capital improvements, staffing and training will be significant, those expenditures – which will increase efficiency, coordination and outcomes - will allow the Collaborators to deliver more care and services that are already covered by Medicaid or other sources, thereby achieving sustainability.

To the extent the Collaborative has not yet achieved full sustainability as planned when the Transformation Funds have been exhausted, the Collaborative is identifying options and solutions to ensure the work of the Collaborative remains fully funded beyond the Transformation Program for the betterment of the Tri-County community for many years to come. For one, UnityPoint Health will work with the UnityPoint Health – Central Illinois Foundation to develop a fundraising program to ensure ongoing sustainability beyond the Transformation Program. Similarly, the Gilmore Foundation has expressed interest in working with the Collaborative and investing in this proposal and its solutions to address the immediate behavioral health crises in the region as well as its plan to advance a diverse, sustainable workforce for mental behavioral health treatment services.

Illinois House of Representatives

District Office:  
300 E. War Memorial Drive #303  
Peoria, IL 61614  
309.681.1992



Springfield Address:  
632 State House  
Springfield, IL 62706  
217.782.3186

## Jehan Gordon-Booth

Deputy Majority Leader • Speaker Pro Tempore  
State Representative • 92nd District

November 19, 2021

Director Theresa Eagleson  
Illinois Department of Healthcare and Family Services  
Prescott Bloom Building  
201 South Grand Avenue, East  
Springfield, Illinois 62763

Re: Expression of Support for Youth and Family Health Collaborative's  
Transformation Proposal

Dear Director Eagleson,

Please accept this letter expressing my strong support for the Youth and Family Health Collaborative and the proposal they will be submitting for your review as part of the Illinois Healthcare Transformation Program.

When the General Assembly amended the Public Aid Code at Section 305 ILCS 5/14-12(d-5)(2) to provide funding for health care transformation, the intent was to ensure that collaborations focused on increasing access and reducing disparities in some of our state's most disadvantaged areas were prioritized. My hometown – Peoria - is one such area that is in desperate need of a transformative approach to healthcare, and specifically mental health, behavioral health, and substance use treatment services.

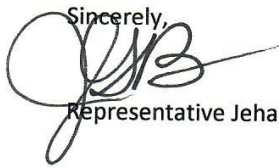
As the State Representative for the 92nd District, I have seen and understand the trauma and tragedies that too many families in the Tri-County Area experience. In fact, my family has first-hand, personal experience with the devastating violence that plagues the Peoria area and its families. Although we are fortunate to have quality community supports and healthcare services, those supports, and services are underfunded and overwhelmed because the demand for those services far exceed what is available. Methodist Medical Center is the only health system that provides inpatient mental and behavioral health services, but they lack the capacity and capability to serve all the youth who need services.

I believe an innovative and transformational approach to pediatric and adolescent behavioral health is critically important to the Tri-County Region, and particularly Peoria County. I fully support this proposal that brings healthcare providers and community supports together to develop a unified,

SOYBEAN INKS

efficient, and effective approach to reach and serve more families in crisis. Respectfully, I request your office grant and approve the proposal at the full amount requested.

Sincerely,

A handwritten signature in black ink, appearing to be 'JGB', written over the word 'Sincerely,'.

Representative Jehan Gordon-Booth



ILLINOIS STATE SENATE  
**DAVID KOEHLER**  
STATE SENATOR • 46TH DISTRICT  
ASSISTANT MAJORITY LEADER

November 19, 2021

Director Theresa Eagleson  
Illinois Department of Healthcare and Family Services  
Prescott Bloom Building  
201 South Grand Avenue, East  
Springfield, Illinois 62763

Re: Letter in Support of Youth and Family Health Collaborative

Dear Director Eagleson,

I am proud to offer my support for the Healthcare Transformation Proposal the Youth and Family Health Collaborative will be submitting to your office to improve access to and delivery of child and adolescent behavioral health, mental health, and substance abuse treatment services in the Tri-County Region. This proposal seeks to improve services through transformative treatment facilities and programs in the Tri-County Area, which will specifically benefit the most vulnerable and distressed areas of Peoria County.

In my Senate work with your office and the Illinois managed care program, I recognize and appreciate the need for improved mental health, behavioral health, and substance use treatment in many parts of Illinois. However, my personal experience with the violence, poverty, and other social challenges we face in the Peoria and the Tri-County Region drives my support for this proposal. Mental health does not discriminate, and mental needs cross all socioeconomic classes. However, disparities exist in parts of our state – and particularly in the Tri-County Region. Our region has pockets of extremely depressed areas with high unemployment, high poverty rate, food insecurity and reduced access to transportation, which creates insurmountable obstacles for families to find healthcare and support services related to mental health. A collaborative approach for a continuum of care model is a necessity to address this crisis.

Having learned what this collaboration intends to do as a collective to increase access and coordination of quality services, I believe their proposal is exactly what the Healthcare Transformation Program needs. I respectfully request your office accept the proposal and issue funds at the amount requested.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Koehler", with a long horizontal flourish extending to the right.

State Senator Dave Koehler  
Assistant Majority Leader  
46<sup>th</sup> Legislative District





# WIN STOLLER

STATE SENATOR • 37TH DISTRICT

SENATORSTOLLER@GMAIL.COM • WWW.SENATORSTOLLER.COM

November 16, 2021

Theresa Eagleson, Director  
Illinois Department of Healthcare and Family Services  
Prescott Bloom Building  
201 South Grand Avenue, East  
Springfield, Illinois 62763

**CAPITOL OFFICE:**

105B STATE HOUSE  
SPRINGFIELD, IL 62706  
(217) 782-1942

**DISTRICT OFFICE:**

5415 N. UNIVERSITY  
SUITE 105  
PEORIA, IL 61614  
(309) 693-4921

Dear Director Eagleson:

As a State Senator and long-time resident of the Peoria area, please accept this letter in support of the Youth and Family Health Collaborative's proposal seeking Healthcare Transformation Funds to reduce health disparities in the Tri-County Region, including Peoria County.

As a member of the Senate Public Safety Committee, I recognize the important role mental health services play in promoting safer communities. Sadly, my home community is plagued by violence and I am troubled by the impact this violence is having on our younger generations. As a resident and business owner, I understand and appreciate the importance of protecting our children and ensuring that they can access and receive critical services close to their home and families.

I strongly support this proposal because of its focus on a collaborative, unified approach among healthcare and community providers to improve access to mental health services through the coordinated delivery of evidence-based interventions. I firmly believe that, if funded, this collaborative will make a remarkable difference on the lives of our area children and families.

Respectfully,

A handwritten signature in black ink, appearing to read 'Win Stoller', is written over a horizontal line.

Win Stoller  
State Senator, 37th District



OFFICE OF THE MAYOR  
RITA ALI

November 19, 2021

Theresa Eagleson, Director  
Illinois Department of Healthcare and Family Services  
Prescott Bloom Building  
201 South Grand Avenue, East  
Springfield, Illinois 62763

Re: Letter of Support for Youth and Family Health Collaborative

Dear Director Eagleson,

Please accept this letter in support of the Youth and Family Health Collaborative's proposal to the Illinois Healthcare Transformation Program for funding to increase access to and reduce disparities related to mental health, behavioral health and substance use treatment services for children and adolescents in the Tri-County Area. We strongly support this grant application and its focus on a coordinated approach expanding community outreach and increasing the delivery of evidence-based interventions in a coordinated way among all area providers.

Prior to becoming the mayor of Peoria, I spent the better part of my life and career helping those less fortunate and developing awareness and action surrounding diversity initiatives. At the age of fourteen, I took my first job with House of Peace, a community outreach program on Peoria's South Side. From that first job until now, I have seen how untreated mental and behavioral health issues plague individuals, families, and communities. I know first-hand that our community desperately needs more access to quality mental and behavioral health services. But I also recognize the need to develop meaningful jobs and careers for persons of color. This proposal does both.

We can do better and I am proud to see our area healthcare and community service providers come together and develop an innovative approach to reach more children, more effectively and in a way that will strengthen our community.

I believe this proposal can have a profound impact on our area's children, families, and workers. I respectfully request your office approve the proposal and fund the collaborative at the full amount requested.

Sincerely,

A handwritten signature in blue ink that reads "Rita Ali".

Rita Ali, Mayor  
rali@peoriagov.org

Peoria City Hall  
419 Fulton Street, Room 207, Peoria, IL 61602  
Phone 309.494.8519 Fax 309.494.8556



**Dr. Sharon Desmoulin-Kherat**  
**Superintendent**

November 15, 2021

Theresa Eagleson  
Director, Illinois Department of Healthcare and Family Services  
Prescott Bloom Building  
201 South Grand Avenue, East  
Springfield, Illinois 62763

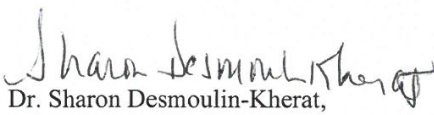
Dear Director Eagleson,

I write on behalf of the Peoria Public Schools in support of the Youth and Family Health Collaborative's proposal to the Illinois Healthcare Transformation Program for funding to increase access to and reduce disparities related to mental health, behavioral health and substance use treatment services for children and adolescents in the Tri-County Area. We strongly support this grant application and its focus on a coordinated approach expanding community outreach and, particularly outreach to our students, using evidence-based, trauma-informed programming.

As Superintendent, I have seen an escalation in school violence every year. When your community goes so does your schools. Although school is a place for learning and intellectual growth, it is a microcosm of our community are forced to double as a social service provider. The trauma our students experience at home and in community manifest in their behaviors at school. These behaviors have the adverse consequence of preventing the learning and growth that we could otherwise achieve. Earlier this year, I made the difficult decision to close one high school one hour early for a day because of my deep concern for student safety after several violent fights erupted among students and some individuals from the community. Our schools and our community need more help supporting our students' mental and behavioral health – which is exactly what the Youth and Family Health Collaborative can and will do. I cannot highlight how critical it is to have these Collaborators come together to expand their reach into the community, and into our schools, with improved coordination and shared evidence-based approaches. This proposal provides much needed help to stop, and hopefully reverse, the escalating violence.

On behalf of the Peoria Public Schools, we look forward to working with this collaboration towards improving the health and lives of our area youth. To that end, we respectfully request to approve the proposal and fund the collaborative at the full amount.

Sincerely,

  
Dr. Sharon Desmoulin-Kherat,  
Superintendent, Peoria Public Schools



## OFFICE OF PEORIA COUNTY CORONER

**JAMIE HARWOOD, BSN, RN, CFN**  
506 E. Seneca Place  
Peoria, Illinois 61603

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**PH: 309-669-2000 • FAX: 309-669-2005 • E-MAIL: [jharwood@peoriacounty.org](mailto:jharwood@peoriacounty.org)**

November 19, 2021

Theresa Eagleson  
Director  
Illinois Department of Healthcare and Family Services  
Prescott Bloom Building  
201 South Grand Avenue, East  
Springfield, Illinois 62763

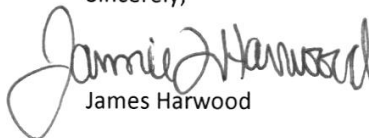
Dear Director Eagleson,

By way of introduction, I am the Peoria County Coroner. I write to you in support of the Youth and Family Health Collaborative's proposal to the Illinois Healthcare Transformation Program for funding to increase access to and reduce disparities related to mental health, behavioral health and substance use treatment services for children and adolescents in the Tri-County Area. I strongly support this grant application and its focus on a coordinated approach improving mental and behavioral health in our region.

In my role, I have the unfortunate experience of seeing far too many adolescent deaths due to addiction, overdose, and suicide. I have been very vocal and active in providing first responders with access to life-saving interventions when they encounter an overdose. However, our community must do more to prevent the overdose from requiring treatment. Our adolescents who struggle with addiction and mental health issues can get well and want to get well, but there are too many obstacles and barriers that prevent them from receiving the treatment and services that will save their lives. Our area needs more hospital beds for inpatient substance use treatment and needs increased support for outpatient follow-through.

Having reviewed the Youth and Family Health Collaborative's plan for increasing services, increasing access, and expanding outreach, I truly believe this program will save lives. I implore you to consider the need in our area and fund the proposal at the fully amount requested.

Sincerely,



James Harwood

Peoria County Coroner





PEORIA POLICE DEPARTMENT

November 15, 2021

Theresa Eagleson  
Illinois Department of Healthcare and Family Services  
Prescott Bloom Building  
201 South Grand Avenue, East  
Springfield, Illinois 62763


Dear Director Eagleson,

I write on behalf of Law Enforcement in support of the Youth and Family Health Collaborative's proposal to the Illinois Healthcare Transformation Program for funding to increase access to and reduce disparities related to mental health, behavioral health and substance use treatment services for children and adolescents in the Tri-County Area. We strongly support this grant application and its focus on a coordinated approach expanding community outreach and increasing the delivery of evidence-based interventions in a coordinated way among all area providers.

This transformative approach simply must happen. In two separate incidents, Peoria's 29<sup>th</sup> and 30<sup>th</sup> homicides of the year were sadly a 15 year-old victim and an infant. These young men in our community don't know how to deal with the issues that they're facing and are quick to pull a gun out and shoot somebody.

We look forward to working with this collaboration towards improving the health and lives of our area youth. To that end, we respectfully request to approve the proposal and fund the collaborative at the full amount.

Sincerely,



Eric Echevarria  
Chief of Police  
City of Peoria

600 S. W. Adams Street  
Peoria, IL 61602-1592  
Phone 309.494.8300

## Section 12. Jobs - Existing Employees by Category and Zip Code

| Organization                   | Job Title             | Zip Code | Count |
|--------------------------------|-----------------------|----------|-------|
| Hult Center for Healthy Living | Admin. Asst.          | 61604    | 1     |
| Hult Center for Healthy Living | Asst. Mngr.           | 61526    | 1     |
| Hult Center for Healthy Living | Comm. Health Coord.   | 61614    | 1     |
| Hult Center for Healthy Living | Exec. Dir.            | 60615    | 1     |
| Hult Center for Healthy Living | Health Ed. Specialist | 61550    | 1     |
| Hult Center for Healthy Living | Health Ed. Specialist | 61614    | 4     |
| Hult Center for Healthy Living | LCPC                  | 61604    | 1     |
| Hult Center for Healthy Living | LCPC                  | 61729    | 1     |
| Hult Center for Healthy Living | Registered Dietician  | 61571    | 1     |
| Hult Center for Healthy Living | Registered Dietician  | 61615    | 1     |
| Univ. of Illinois              | Pediatric Asst. Prof. | 61071    | 1     |
| Univ. of Illinois              | Pediatric Asst. Prof. | 61488    | 1     |
| Univ. of Illinois              | Pediatric Asst. Prof. | 61491    | 1     |
| Univ. of Illinois              | Pediatric Asst. Prof. | 61525    | 1     |
| Univ. of Illinois              | Pediatric Asst. Prof. | 61548    | 1     |
| Univ. of Illinois              | Pediatric Asst. Prof. | 61550    | 1     |
| Univ. of Illinois              | Pediatric Asst. Prof. | 61554    | 2     |
| Univ. of Illinois              | Pediatric Asst. Prof. | 61603    | 1     |
| Univ. of Illinois              | Pediatric Asst. Prof. | 61605    | 1     |
| Univ. of Illinois              | Pediatric Asst. Prof. | 61614    | 4     |
| Univ. of Illinois              | Pediatric Asst. Prof. | 61615    | 3     |
| Univ. of Illinois              | Pediatric Asst. Prof. | 61725    | 1     |
| Univ. of Illinois              | Pediatric Asst. Prof. | 61732    | 1     |
| Univ. of Illinois              | Pediatric Asst. Prof. | 61751    | 2     |
| Univ. of Illinois              | Pediatric Asst. Prof. | 61755    | 1     |
| Univ. of Illinois              | Pediatric Asst. Prof. | 62693    | 1     |
| Univ. of Illinois              | Pediatric Faculty     | 46375    | 1     |
| Univ. of Illinois              | Pediatric Faculty     | 52722    | 1     |
| Univ. of Illinois              | Pediatric Faculty     | 55337    | 1     |
| Univ. of Illinois              | Pediatric Faculty     | 60110    | 1     |
| Univ. of Illinois              | Pediatric Faculty     | 60465    | 1     |
| Univ. of Illinois              | Pediatric Faculty     | 60712    | 1     |
| Univ. of Illinois              | Pediatric Faculty     | 61525    | 20    |
| Univ. of Illinois              | Pediatric Faculty     | 61528    | 2     |
| Univ. of Illinois              | Pediatric Faculty     | 61528    | 2     |
| Univ. of Illinois              | Pediatric Faculty     | 61535    | 1     |
| Univ. of Illinois              | Pediatric Faculty     | 61536    | 1     |
| Univ. of Illinois              | Pediatric Faculty     | 61547    | 1     |
| Univ. of Illinois              | Pediatric Faculty     | 61548    | 2     |
| Univ. of Illinois              | Pediatric Faculty     | 61550    | 3     |
| Univ. of Illinois              | Pediatric Faculty     | 61559    | 1     |
| Univ. of Illinois              | Pediatric Faculty     | 61569    | 1     |
| Univ. of Illinois              | Pediatric Faculty     | 61571    | 5     |
| Univ. of Illinois              | Pediatric Faculty     | 61602    | 4     |
| Univ. of Illinois              | Pediatric Faculty     | 61606    | 1     |

YFBHC Proposal

Section 12. Jobs

Existing employees by category and zip code

Page 1 of 9

| <b>Organization</b>       | <b>Job Title</b>   | <b>Zip Code</b> | <b>Count</b> |
|---------------------------|--------------------|-----------------|--------------|
| Univ. of Illinois         | Pediatric Faculty  | 61611           | 2            |
| Univ. of Illinois         | Pediatric Faculty  | 61614           | 13           |
| Univ. of Illinois         | Pediatric Faculty  | 61615           | 41           |
| Univ. of Illinois         | Pediatric Faculty  | 61729           | 1            |
| Univ. of Illinois         | Pediatric Faculty  | 62704           | 2            |
| Univ. of Illinois         | Pediatric Staff    | 61008           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61401           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61520           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61523           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61525           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61530           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61548           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61550           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61554           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61559           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61561           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61570           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61571           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61603           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61604           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61605           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61606           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61607           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61611           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61614           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61615           | 1            |
| Univ. of Illinois         | Pediatric Staff    | 61616           | 1            |
| Univ. of Illinois         | Psychiatry Faculty | 61401           | 1            |
| Univ. of Illinois         | Psychiatry Faculty | 61525           | 3            |
| Univ. of Illinois         | Psychiatry Faculty | 61536           | 1            |
| Univ. of Illinois         | Psychiatry Faculty | 61554           | 1            |
| Univ. of Illinois         | Psychiatry Faculty | 61604           | 1            |
| Univ. of Illinois         | Psychiatry Faculty | 61606           | 1            |
| Univ. of Illinois         | Psychiatry Faculty | 61611           | 1            |
| Univ. of Illinois         | Psychiatry Faculty | 61614           | 2            |
| Univ. of Illinois         | Psychiatry Faculty | 61615           | 2            |
| Univ. of Illinois         | Psychiatry Staff   | 61427           | 1            |
| Univ. of Illinois         | Psychiatry Staff   | 61536           | 2            |
| Univ. of Illinois         | Psychiatry Staff   | 61559           | 1            |
| Univ. of Illinois         | Psychiatry Staff   | 61571           | 1            |
| Univ. of Illinois         | Psychiatry Staff   | 61604           | 1            |
| Univ. of Illinois         | Psychiatry Staff   | 61607           | 1            |
| Univ. of Illinois         | Psychiatry Staff   | 61611           | 1            |
| Heartland Health Services | Clinical           | 61548           | 1            |
| Heartland Health Services | Clinical           | 61401           | 1            |
| Heartland Health Services | Clinical           | 61525           | 2            |

**YFBHC Proposal**

**Section 12. Jobs**

**Existing employees by category and zip code**

**Page 2 of 9**

| <b>Organization</b>       | <b>Job Title</b> | <b>Zip Code</b> | <b>Count</b> |
|---------------------------|------------------|-----------------|--------------|
| Heartland Health Services | Clinical         | 61537           | 1            |
| Heartland Health Services | Clinical         | 61550           | 2            |
| Heartland Health Services | Clinical         | 61554           | 16           |
| Heartland Health Services | Clinical         | 61559           | 1            |
| Heartland Health Services | Clinical         | 61564           | 1            |
| Heartland Health Services | Clinical         | 61571           | 2            |
| Heartland Health Services | Clinical         | 61603           | 5            |
| Heartland Health Services | Clinical         | 61604           | 7            |
| Heartland Health Services | Clinical         | 61605           | 5            |
| Heartland Health Services | Clinical         | 61606           | 2            |
| Heartland Health Services | Clinical         | 61607           | 3            |
| Heartland Health Services | Clinical         | 61610           | 2            |
| Heartland Health Services | Clinical         | 61611           | 8            |
| Heartland Health Services | Clinical         | 61614           | 6            |
| Heartland Health Services | Clinical         | 61615           | 6            |
| Heartland Health Services | Clinical         | 61616           | 3            |
| Heartland Health Services | Clinical         | 61734           | 1            |
| Heartland Health Services | Clinical         | 61742           | 1            |
| Heartland Health Services | Clinical         | 62644           | 1            |
| Heartland Health Services | Leadership       | 61523           | 1            |
| Heartland Health Services | Leadership       | 61525           | 4            |
| Heartland Health Services | Leadership       | 61533           | 1            |
| Heartland Health Services | Leadership       | 61535           | 1            |
| Heartland Health Services | Leadership       | 61554           | 1            |
| Heartland Health Services | Leadership       | 61571           | 1            |
| Heartland Health Services | Leadership       | 61603           | 1            |
| Heartland Health Services | Leadership       | 61611           | 1            |
| Heartland Health Services | Leadership       | 61614           | 1            |
| Heartland Health Services | Leadership       | 61615           | 2            |
| Heartland Health Services | Leadership       | 61705           | 1            |
| Heartland Health Services | Leadership       | 61764           | 1            |
| Heartland Health Services | Provider         | 60431           | 1            |
| Heartland Health Services | Provider         | 60656           | 1            |
| Heartland Health Services | Provider         | 61523           | 1            |
| Heartland Health Services | Provider         | 61525           | 5            |
| Heartland Health Services | Provider         | 61528           | 1            |
| Heartland Health Services | Provider         | 61535           | 1            |
| Heartland Health Services | Provider         | 61548           | 1            |
| Heartland Health Services | Provider         | 61554           | 1            |
| Heartland Health Services | Provider         | 61568           | 1            |
| Heartland Health Services | Provider         | 61603           | 1            |
| Heartland Health Services | Provider         | 61604           | 4            |
| Heartland Health Services | Provider         | 61606           | 2            |
| Heartland Health Services | Provider         | 61611           | 2            |
| Heartland Health Services | Provider         | 61612           | 1            |
| Heartland Health Services | Provider         | 61614           | 4            |

YFBHC Proposal

Section 12. Jobs

Existing employees by category and zip code

Page 3 of 9



| <b>Organization</b>         | <b>Job Title</b>                     | <b>Zip Code</b> | <b>Count</b> |
|-----------------------------|--------------------------------------|-----------------|--------------|
| Heartland Health Services   | Provider                             | 61615           | 7            |
| Heartland Health Services   | Provider                             | 61616           | 3            |
| Heartland Health Services   | Provider                             | 62634           | 1            |
| Heartland Health Services   | Support                              | 61523           | 2            |
| Heartland Health Services   | Support                              | 61548           | 1            |
| Heartland Health Services   | Support                              | 61550           | 1            |
| Heartland Health Services   | Support                              | 61554           | 7            |
| Heartland Health Services   | Support                              | 61571           | 6            |
| Heartland Health Services   | Support                              | 61603           | 7            |
| Heartland Health Services   | Support                              | 61604           | 9            |
| Heartland Health Services   | Support                              | 61605           | 5            |
| Heartland Health Services   | Support                              | 61610           | 2            |
| Heartland Health Services   | Support                              | 61611           | 1            |
| Heartland Health Services   | Support                              | 61614           | 8            |
| Heartland Health Services   | Support                              | 61615           | 4            |
| Heartland Health Services   | Support                              | 61616           | 2            |
| Heartland Health Services   | Support                              | 61625           | 1            |
| Heartland Health Services   | Support                              | 61734           | 1            |
| Heartland Health Services   | Support                              | 61755           | 1            |
| Heartland Health Services   | Support                              | 62644           | 1            |
| Children's Home of Illinois | Therapist                            | 61321           | 1            |
| Children's Home of Illinois | Assistant Clinical Coord.            | 61327           | 1            |
| Children's Home of Illinois | Clinical Coord                       | 61401           | 1            |
| Children's Home of Illinois | Therapist                            | 61401           | 1            |
| Children's Home of Illinois | IFC Community Development Specialist | 61483           | 1            |
| Children's Home of Illinois | Vice President                       | 61520           | 1            |
| Children's Home of Illinois | Doula                                | 61523           | 1            |
| Children's Home of Illinois | Therapist                            | 61523           | 1            |
| Children's Home of Illinois | Program Coordinator                  | 61525           | 2            |
| Children's Home of Illinois | Therapist                            | 61525           | 4            |
| Children's Home of Illinois | Family Support Specialist            | 61526           | 1            |
| Children's Home of Illinois | Clinical Coord                       | 61530           | 1            |
| Children's Home of Illinois | Family Support Spec                  | 61531           | 1            |
| Children's Home of Illinois | Therapist                            | 61534           | 1            |
| Children's Home of Illinois | Counselor                            | 61547           | 1            |
| Children's Home of Illinois | Lead Mental Health Consultant        | 61547           | 1            |
| Children's Home of Illinois | Therapist                            | 61547           | 1            |
| Children's Home of Illinois | Clinical Coord                       | 61548           | 1            |
| Children's Home of Illinois | Lead Therapist                       | 61548           | 1            |
| Children's Home of Illinois | Therapist                            | 61548           | 2            |
| Children's Home of Illinois | Therapist                            | 61550           | 2            |
| Children's Home of Illinois | Admin. Assistant                     | 61554           | 1            |
| Children's Home of Illinois | Associate Director                   | 61554           | 1            |
| Children's Home of Illinois | Counselor                            | 61554           | 1            |
| Children's Home of Illinois | Registered Nurse                     | 61554           | 1            |
| Children's Home of Illinois | Therapist                            | 61554           | 2            |

**YFBHC Proposal**

**Section 12. Jobs**

**Existing employees by category and zip code**

**Page 4 of 9**

| <b>Organization</b>         | <b>Job Title</b>          | <b>Zip Code</b> | <b>Count</b> |
|-----------------------------|---------------------------|-----------------|--------------|
| Children's Home of Illinois | Associate Director        | 61571           | 1            |
| Children's Home of Illinois | Food Ser. Wrkr GB         | 61571           | 1            |
| Children's Home of Illinois | Counselor                 | 61603           | 2            |
| Children's Home of Illinois | Family Support Worker     | 61603           | 1            |
| Children's Home of Illinois | Therapist                 | 61603           | 4            |
| Children's Home of Illinois | Clinical Coordinator      | 61604           | 2            |
| Children's Home of Illinois | Counselor                 | 61604           | 1            |
| Children's Home of Illinois | Family Support Worker     | 61604           | 2            |
| Children's Home of Illinois | Lead Counselor            | 61604           | 1            |
| Children's Home of Illinois | Registered Nurse          | 61604           | 1            |
| Children's Home of Illinois | Therapist                 | 61604           | 4            |
| Children's Home of Illinois | Therapist                 | 61606           | 1            |
| Children's Home of Illinois | Early Child Men Hlth Con  | 61607           | 1            |
| Children's Home of Illinois | Family Support Spec       | 61607           | 1            |
| Children's Home of Illinois | Clinical Coord            | 61610           | 1            |
| Children's Home of Illinois | Admin. Assistant          | 61611           | 1            |
| Children's Home of Illinois | Coord. Intake Worker      | 61611           | 1            |
| Children's Home of Illinois | Counselor                 | 61611           | 2            |
| Children's Home of Illinois | Fam Sup Worker            | 61611           | 1            |
| Children's Home of Illinois | MHJJ Counselor            | 61611           | 1            |
| Children's Home of Illinois | Registered Nurse          | 61611           | 1            |
| Children's Home of Illinois | Counselor                 | 61614           | 1            |
| Children's Home of Illinois | Doula                     | 61614           | 1            |
| Children's Home of Illinois | Family Support Worker     | 61614           | 2            |
| Children's Home of Illinois | Family Resource Developer | 61614           | 1            |
| Children's Home of Illinois | Intake Assess Specialist  | 61614           | 1            |
| Children's Home of Illinois | Lead Therapist            | 61614           | 1            |
| Children's Home of Illinois | Program Director          | 61614           | 1            |
| Children's Home of Illinois | Registered Nurse          | 61614           | 2            |
| Children's Home of Illinois | Therapist                 | 61614           | 3            |
| Children's Home of Illinois | Comm. Outreach and PSW    | 61615           | 1            |
| Children's Home of Illinois | Counselor                 | 61615           | 1            |
| Children's Home of Illinois | Prog. Coordinator         | 61615           | 1            |
| Children's Home of Illinois | Program Director          | 61615           | 1            |
| Children's Home of Illinois | Registered Nurse          | 61615           | 1            |
| Children's Home of Illinois | Therapist                 | 61615           | 6            |
| Children's Home of Illinois | Counselor                 | 61701           | 1            |
| Children's Home of Illinois | Therapist                 | 61701           | 1            |
| Children's Home of Illinois | Therapist                 | 61734           | 1            |
| Children's Home of Illinois | Assist. Clinical Coord    | 61761           | 1            |
| Children's Home of Illinois | Therapist - BA            | 62656           | 1            |
| UnityPoint Health           | Executive                 | 61547           | 2            |
| UnityPoint Health           | Director                  | 61745           | 1            |
| UnityPoint Health           | Director                  | 61535           | 1            |
| UnityPoint Health           | Director                  | 61611           | 1            |
| UnityPoint Health           | Director                  | 61571.00        | 1            |

**YFBHC Proposal**

**Section 12. Jobs**

**Existing employees by category and zip code**

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| <b>Organization</b> | <b>Job Title</b>       | <b>Zip Code</b> | <b>Count</b> |
|---------------------|------------------------|-----------------|--------------|
| UnityPoint Health   | Manager                | 61615           | 2            |
| UnityPoint Health   | Manager                | 61616           | 1            |
| UnityPoint Health   | Manager                | 61607           | 1            |
| UnityPoint Health   | Manager                | 61604           | 1            |
| UnityPoint Health   | Supervisory            | 61604           | 1            |
| UnityPoint Health   | Supervisory            | 61531           | 1            |
| UnityPoint Health   | Supervisory            | 61611           | 1            |
| UnityPoint Health   | Supervisory            | 61401           | 1            |
| UnityPoint Health   | Supervisory            | 61571           | 1            |
| UnityPoint Health   | Physician              | 61614           | 1            |
| UnityPoint Health   | Administrative Support | 61554           | 1            |
| UnityPoint Health   | Administrative Support | 61604           | 1            |
| UnityPoint Health   | Administrative Support | 61611           | 1            |
| UnityPoint Health   | Administrative Support | 61614           | 1            |
| UnityPoint Health   | Administrative Support | 61615           | 1            |
| UnityPoint Health   | Administrative Support | 61616           | 1            |
| UnityPoint Health   | Administrative Support | 61734           | 1            |
| UnityPoint Health   | Direct Care Provider   | 40222           | 1            |
| UnityPoint Health   | Direct Care Provider   | 52208           | 1            |
| UnityPoint Health   | Direct Care Provider   | 60045           | 1            |
| UnityPoint Health   | Direct Care Provider   | 61201           | 1            |
| UnityPoint Health   | Direct Care Provider   | 61310           | 1            |
| UnityPoint Health   | Direct Care Provider   | 61342           | 1            |
| UnityPoint Health   | Direct Care Provider   | 61369           | 1            |
| UnityPoint Health   | Direct Care Provider   | 61401           | 1            |
| UnityPoint Health   | Direct Care Provider   | 61423           | 1            |
| UnityPoint Health   | Direct Care Provider   | 61443           | 3            |
| UnityPoint Health   | Direct Care Provider   | 61491           | 2            |
| UnityPoint Health   | Direct Care Provider   | 61516           | 1            |
| UnityPoint Health   | Direct Care Provider   | 61517           | 1            |
| UnityPoint Health   | Direct Care Provider   | 61520           | 4            |
| UnityPoint Health   | Direct Care Provider   | 61523           | 6            |
| UnityPoint Health   | Direct Care Provider   | 61525           | 5            |
| UnityPoint Health   | Direct Care Provider   | 61529           | 1            |
| UnityPoint Health   | Direct Care Provider   | 61531           | 1            |
| UnityPoint Health   | Direct Care Provider   | 61533           | 3            |
| UnityPoint Health   | Direct Care Provider   | 61534           | 1            |
| UnityPoint Health   | Direct Care Provider   | 61535           | 3            |
| UnityPoint Health   | Direct Care Provider   | 61537           | 1            |
| UnityPoint Health   | Direct Care Provider   | 61545           | 1            |
| UnityPoint Health   | Direct Care Provider   | 61546           | 3            |
| UnityPoint Health   | Direct Care Provider   | 61547           | 3            |
| UnityPoint Health   | Direct Care Provider   | 61548           | 7            |
| UnityPoint Health   | Direct Care Provider   | 61550           | 6            |
| UnityPoint Health   | Direct Care Provider   | 61554           | 22           |
| UnityPoint Health   | Direct Care Provider   | 61561           | 1            |

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Section 12. Jobs

Existing employees by category and zip code

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| <b>Organization</b>  | <b>Job Title</b>       | <b>Zip Code</b> | <b>Count</b> |
|----------------------|------------------------|-----------------|--------------|
| UnityPoint Health    | Direct Care Provider   | 61565           | 1            |
| UnityPoint Health    | Direct Care Provider   | 61568           | 1            |
| UnityPoint Health    | Direct Care Provider   | 61571           | 1            |
| UnityPoint Health    | Direct Care Provider   | 61571           | 22           |
| UnityPoint Health    | Direct Care Provider   | 61603           | 10           |
| UnityPoint Health    | Direct Care Provider   | 61604           | 19           |
| UnityPoint Health    | Direct Care Provider   | 61605           | 3            |
| UnityPoint Health    | Direct Care Provider   | 61606           | 12           |
| UnityPoint Health    | Direct Care Provider   | 61607           | 11           |
| UnityPoint Health    | Direct Care Provider   | 61611           | 13           |
| UnityPoint Health    | Direct Care Provider   | 61614           | 28           |
| UnityPoint Health    | Direct Care Provider   | 61615           | 34           |
| UnityPoint Health    | Direct Care Provider   | 61616           | 5            |
| UnityPoint Health    | Direct Care Provider   | 61701           | 2            |
| UnityPoint Health    | Direct Care Provider   | 61745           | 1            |
| UnityPoint Health    | Direct Care Provider   | 61755           | 1            |
| UnityPoint Health    | Direct Care Provider   | 61761           | 3            |
| UnityPoint Health    | Direct Care Provider   | 62644           | 1            |
| UnityPoint Health    | Direct Care Provider   | 62707           | 1            |
| UnityPoint Health    | Direct Care Provider   | 62711           | 1            |
| UnityPoint Health    | Direct Care Provider   | 62901           | 1            |
| UnityPoint Health    | Direct Care Provider   | 76058           | 1            |
| UnityPoint Health    | Direct Care Provider   | Unknown         | 6            |
| UnityPoint Health    | Service Provider       | 61614           | 1            |
| UnityPoint Health    | Service Provider       | 61569           | 1            |
| UnityPoint Health    | Service Provider       | 61604           | 1            |
| UnityPoint Health    | Service Provider       | 61606           | 1            |
| UnityPoint Health    | Service Provider       | 61755           | 1            |
| UnityPoint Health    | Service Provider       | 61529           | 1            |
| UnityPoint Health    | Service Provider       | 61401           | 1            |
| Human Service Center | Administrative Support | 61520           |              |
| Human Service Center | Administrative Support | 61523           | 2            |
| Human Service Center | Administrative Support | 61526           | 1            |
| Human Service Center | Administrative Support | 61530           | 1            |
| Human Service Center | Administrative Support | 61548           | 1            |
| Human Service Center | Administrative Support | 61550           | 1            |
| Human Service Center | Administrative Support | 61554           | 3            |
| Human Service Center | Administrative Support | 61571           | 5            |
| Human Service Center | Administrative Support | 61603           | 1            |
| Human Service Center | Administrative Support | 61604           | 6            |
| Human Service Center | Administrative Support | 61605           | 2            |
| Human Service Center | Administrative Support | 61607           | 1            |
| Human Service Center | Administrative Support | 61614           | 2            |
| Human Service Center | Administrative Support | 61615           | 4            |
| Human Service Center | Administrative Support | 61616           | 1            |
| Human Service Center | Administrative Support | 61704           | 1            |

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Section 12. Jobs

Existing employees by category and zip code

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| <b>Organization</b>  | <b>Job Title</b>     | <b>Zip Code</b> | <b>Count</b> |
|----------------------|----------------------|-----------------|--------------|
| Human Service Center | Direct Care Provider | 61401           | 1            |
| Human Service Center | Direct Care Provider | 61443           | 2            |
| Human Service Center | Direct Care Provider | 61449           | 1            |
| Human Service Center | Direct Care Provider | 61489           | 1            |
| Human Service Center | Direct Care Provider | 61520           | 3            |
| Human Service Center | Direct Care Provider | 61523           | 7            |
| Human Service Center | Direct Care Provider | 61525           | 5            |
| Human Service Center | Direct Care Provider | 61530           | 2            |
| Human Service Center | Direct Care Provider | 61534           | 1            |
| Human Service Center | Direct Care Provider | 61547           | 2            |
| Human Service Center | Direct Care Provider | 61548           | 2            |
| Human Service Center | Direct Care Provider | 61550           | 3            |
| Human Service Center | Direct Care Provider | 61554           | 11           |
| Human Service Center | Direct Care Provider | 61561           | 1            |
| Human Service Center | Direct Care Provider | 61571           | 7            |
| Human Service Center | Direct Care Provider | 61601           | 1            |
| Human Service Center | Direct Care Provider | 61603           | 10           |
| Human Service Center | Direct Care Provider | 61604           | 25           |
| Human Service Center | Direct Care Provider | 61605           | 17           |
| Human Service Center | Direct Care Provider | 61606           | 1            |
| Human Service Center | Direct Care Provider | 61607           | 2            |
| Human Service Center | Direct Care Provider | 61610           | 2            |
| Human Service Center | Direct Care Provider | 61611           | 5            |
| Human Service Center | Direct Care Provider | 61614           | 18           |
| Human Service Center | Direct Care Provider | 61615           | 15           |
| Human Service Center | Direct Care Provider | 61616           | 3            |
| Human Service Center | Direct Care Provider | 61704           | 1            |
| Human Service Center | Direct Care Provider | 61705           | 1            |
| Human Service Center | Direct Care Provider | 61755           | 1            |
| Human Service Center | Direct Care Provider | 61761           | 1            |
| Human Service Center | Manager              | 61611           | 2            |
| Human Service Center | Manager              | 61614           | 1            |
| Human Service Center | Manager              | 61615           | 1            |
| Human Service Center | Manager              | 62644           | 1            |
| Human Service Center | Physician            | 61615           | 1            |
| Human Service Center | Service Provider     | 61520           | 1            |
| Human Service Center | Service Provider     | 61525           | 2            |
| Human Service Center | Service Provider     | 61550           | 1            |
| Human Service Center | Service Provider     | 61603           | 1            |
| Human Service Center | Service Provider     | 61604           | 2            |
| Human Service Center | Service Provider     | 61605           | 1            |
| Human Service Center | Service Provider     | 61614           | 3            |
| Human Service Center | Service Provider     | 61615           | 1            |
| Human Service Center | Service Provider     | 61616           | 1            |
| Human Service Center | Service Provider     | 61701           | 1            |
| Human Service Center | Supervisory          | 61520           | 1            |

**YFBHC Proposal**

**Section 12. Jobs**

**Existing employees by category and zip code**

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| <b>Organization</b>          | <b>Job Title</b>       | <b>Zip Code</b> | <b>Count</b> |
|------------------------------|------------------------|-----------------|--------------|
| Human Service Center         | Supervisory            | 61554           | 1            |
| Human Service Center         | Supervisory            | 61603           | 1            |
| Human Service Center         | Supervisory            | 61605           | 1            |
| Human Service Center         | Supervisory            | 61611           | 1            |
| Human Service Center         | Supervisory            | 61614           | 3            |
| Human Service Center         | Supervisory            | 61615           | 2            |
| Human Service Center         | Supervisory            | 61616           | 1            |
| Human Service Center         | Technicians            | 61571           | 1            |
| Human Service Center         | Technicians            | 61604           | 1            |
| Human Service Center         | Technicians            | 61611           | 1            |
| Tazwood Mental Health Center | Administrative Support | 61533           | 1            |
| Tazwood Mental Health Center | Administrative Support | 61534           | 1            |
| Tazwood Mental Health Center | Administrative Support | 61546           | 1            |
| Tazwood Mental Health Center | Administrative Support | 61550           | 1            |
| Tazwood Mental Health Center | Administrative Support | 61554           | 3            |
| Tazwood Mental Health Center | Administrative Support | 61571           | 1            |
| Tazwood Mental Health Center | Administrative Support | 61605           | 1            |
| Tazwood Mental Health Center | Administrative Support | 61611           | 1            |
| Tazwood Mental Health Center | Administrative Support | 62656           | 1            |
| Tazwood Mental Health Center | Direct Care Provider   | 61520           | 3            |
| Tazwood Mental Health Center | Direct Care Provider   | 61531           | 1            |
| Tazwood Mental Health Center | Direct Care Provider   | 61535           | 1            |
| Tazwood Mental Health Center | Direct Care Provider   | 61550           | 3            |
| Tazwood Mental Health Center | Direct Care Provider   | 61554           | 13           |
| Tazwood Mental Health Center | Direct Care Provider   | 61571           | 4            |
| Tazwood Mental Health Center | Direct Care Provider   | 61604           | 2            |
| Tazwood Mental Health Center | Direct Care Provider   | 61607           | 2            |
| Tazwood Mental Health Center | Direct Care Provider   | 61611           | 1            |
| Tazwood Mental Health Center | Direct Care Provider   | 61614           | 2            |
| Tazwood Mental Health Center | Direct Care Provider   | 61615           | 1            |
| Tazwood Mental Health Center | Direct Care Provider   | 61701           | 1            |
| Tazwood Mental Health Center | Direct Care Provider   | 61704           | 1            |
| Tazwood Mental Health Center | Direct Care Provider   | 61761           | 1            |
| Tazwood Mental Health Center | Manager                | 61554           | 1            |
| Tazwood Mental Health Center | Supervisory            | 61546           | 1            |
| Tazwood Mental Health Center | Supervisory            | 61554           | 2            |
| Tazwood Mental Health Center | Supervisory            | 61571           | 1            |
| Tazwood Mental Health Center | Supervisory            | 61615           | 1            |
| Tazwood Mental Health Center | Technicians            | 61605           | 1            |





## **Youth and Family Behavioral Health Collaborative**

Prepared by UnityPoint Health - Methodist  
for Department of Healthcare and Family Services Healthcare Transformation Collaboratives

**Primary Contact: Dean Steiner**



## Opportunity Details

### Opportunity Information

Public Link

<https://il.amplifund.com/Public/Opportunities/Details/25595216-6cc7-40f0-9aa5-0b550dddc17c>

### Question Submission Information

Question Submission Open Date

10/01/2021 12:00 AM

Question Submission Close Date

10/15/2021 11:59 PM

Question Submission Email Address

HFS.Transformation@illinois.gov

Question Submission Additional Information

**1. CONSIDER THE HTC INSTRUCTIONS GUIDE REQUIRED READING FOR HOW TO COMPLETE THE HTC APPLICATION.**

Please read the HTC Application Instructions guide thoroughly, from beginning to end, before beginning your application. These instructions clear up many potential sources of confusion and provide instructions that are essential for submitting a complete and viable HTC application.

In this resource, we provide videos and slides for navigating the HTC application in Amplifund and instructions for completing specific sections of the application. (e.g., how to fill out a budget).

We also provide additional information about the content of the application to help you understand what HFS is looking for in an effective application.

The HTC Application Instructions Guide can be found at this address:

<https://www2.illinois.gov/hfs/HealthcareTransformation/Documents/HTCApplicationInstructionsGuide.pdf>

For a brief checklist to keep your application on track, navigate to <https://www2.illinois.gov/hfs/Pages/htcappinfo.aspx> and find a link.

**2. QUESTIONS ABOUT HTC AND THE SUBSTANCE OF THE APPLICATION ARE DUE BETWEEN OCTOBER 1 AND OCTOBER 15.**

Questions seeking clarity on the HTC program and the substance of the application (as opposed to technical questions) should be sent to HFS.Transformation@illinois.gov. Questions are due before 11:59 pm on October 15, 2021. Answers will be published on the FAQ Page of the HTC website (<https://www2.illinois.gov/hfs/Pages/htcfaqs.aspx>).

HFS will answer questions as soon as possible. Interested parties should regularly check for new questions and answers at the FAQ web address listed above.

For more information about HTC and the application, you may also consult the September 30 informational webinar video and slide presentation, as well as the many resources available to support you in your application. All of these resources are located at the HTC Application Information page (<https://www2.illinois.gov/hfs/Pages/htcappinfo.aspx>).

**3. AMPLIFUND WILL RESPOND WITHIN 2 HOURS TO ALL TECHNICAL SUPPORT QUESTIONS.**

If you are having technical difficulties with Amplifund, you may email your question to [support@il-amplifund.zendesk.com](mailto:support@il-amplifund.zendesk.com) or call 216-377-5500, though callers to this number will likely be directed to the online system. Amplifund guarantees responses to support requests within two hours of questions submitted during business hours.

You may also consult the Amplifund customer support website at <https://il-amplifund.zendesk.com>. At this site, you may submit support tickets and access instructional content. Access to this site requires registration of a new account specifically with the Amplifund Zendesk site.

For a general overview of how to submit an application using Amplifund, you may access a tutorial video provided by Amplifund here: <https://il-amplifund.zendesk.com/hc/en-us/articles/360053747153-Introduction-to-the-Applcant-Portal>

### Additional Information

Additional Information URL

<https://www2.illinois.gov/hfs/Pages/htcappinfo.aspx>

Additional Information URL Description

Please refer to the Application Information page of the Healthcare Transformation Collaboratives website for all information related to the application process.

For information about the program, visit [htc.illinois.gov](http://htc.illinois.gov).

**Project Information****Application Information**

Application Name

Youth and Family Behavioral Health Collaborative

Award Requested

\$36,975,692.00

Cash Match Requirement

\$0.00

Cash Match Contributions

\$0.00

In-Kind Match Requirement

\$0.00

In-Kind Match Contributions

\$0.00

Other Funding Contributions

\$1,392,500.00

Total Award Budget

\$38,368,192.00

**Primary Contact Information**

Name

Dean Steiner

Email Address

Address

221 N.E. Glen Oak  
Peoria, Illinois 61636

Phone Number

## Project Description

### 0. Start Here - Eligibility Screen

#### HELP AND SUPPORT INFORMATION

*If you need help or have a question:*

- For guidance on this form, consult the [HTC Application Instructions resource](#).
- If you have a question about the subject matter of the application, email [HFS.Transformation@illinois.gov](mailto:HFS.Transformation@illinois.gov) before October 15. Questions will not be taken after that date. Check for answers at the [HTC FAQs page](#), which will be updated continuously between October 1 and October 15.
- If you need technical support in Amplifund, email [support@il-amplifund.zendesk.com](mailto:support@il-amplifund.zendesk.com) with your question. All emails sent within business hours (7am-5pm) should receive a response within two hours.
- If you'd like to consult support resources provided by Amplifund: Visit the vendor's [support website](#) for user guides, tutorial videos, and other resources. You will have to register a new and separate account to access content on this site.

#### Eligibility Screen

Note that applications cannot qualify for funding which:

1. fail to include multiple external entities within their collaborative (i.e. entities not within the same organization); or,
2. fail to include one Medicaid-eligible biller.

Does your collaboration include multiple, external, entities?

- ☒ Yes  
☐ No

Can any of the entities in your collaboration bill Medicaid?

- ☒ Yes  
☐ No

Based on your responses to the two questions above, your application meets basic eligibility criteria. You may proceed to complete the remainder of the application.

**When you're finished answering the questions on this page, click [Mark as Complete](#). An application cannot be submitted until all pages are marked as complete.**

Not finished with this page yet? Click [Save](#) or [Save & Continue](#) to fill out the missing information at a later time.

## 1. Participating Entities

### HELP AND SUPPORT INFORMATION

**Note on work process:** We strongly recommend that applicants draft responses to long-form narrative questions locally (i.e. in Microsoft Word) and then copy and paste these responses into Amplifund. Many Amplifund response fields will preserve formatting (e.g. a table, bullet list, or text style) copied from word processing applications, allowing applicants flexibility in how they format their responses.

**If you need help or have a question:**

- For guidance on this form, consult the [HTC Application Instructions resource](#).
- If you have a question about the subject matter of the application, email [HFS.Transformation@illinois.gov](mailto:HFS.Transformation@illinois.gov) before October 15. Questions will not be taken after that date. Check for answers at the [HTC FAQs page](#), which will be updated continuously between October 1 and October 15.
- If you need technical support in Amplifund, email [support@il-amplifund.zendesk.com](mailto:support@il-amplifund.zendesk.com) with your question. All emails sent within business hours (7am-5pm) should receive a response within two hours.
- If you'd like to consult support resources provided by Amplifund: Visit the vendor's [support website](#) for user guides, tutorial videos, and other resources. You will have to register a new and separate account to access content on this site.

### Contact Information for Collaborating Entities

1. What is the name of the lead entity of your collaborative?

Methodist Medical Center of Illinois

2. Please provide primary contact information, secondary contact information, and the Tax ID # of each entity in your collaborative. Please list the lead entity in the top row.

| Entity Name   | Tax ID #<br>(xx-xxxxxx) | Primary Contact             | Position                                   | Email | Office Phone | Mobile Phone | Secondary Contact     | Secondary Contact Position  | Secondary Contact Email |
|---|-------------------------|-----------------------------|--|-------|--------------|--------------|-----------------------|---|-------------------------|
| Methodist Medical Center of Illinois  |                         | Dean Steiner, LCPC          | Acting Chief Operating Officer, UnityPlace |       |              |              | Michael Unes          | Vice President, Foundation  |                         |
| The Board of Trustees of the University of Illinois / University of Illinois College of Medicine Peoria |                         | Sarah E. Donohue, PhD       | Director, Research Services                |       |              |              | Ryan Finkenbine, MD   | Professor and Chair, Department of Psychiatry and Behavioral Medicine |                         |
| UnityPoint Health - UnityPlace  |                         | Dean Steiner, LCPC          | Acting Chief Operating Officer             |       |              |              | Stefanie Gidmark, MPH | Grant Supervisor  |                         |
| Children's Home of Central Illinois   |                         | Cindy Hoffman               | Executive Vice President                   |       |              |              | Stephanie Herink      | Vice President of Clinical Services                                   |                         |
| Heartland Health Services   |                         | Mary-Jennifer Meister, LCSW | Director, Behavioral Health                |       |              |              | Greg Stoner, MD       | Medical Director  |                         |
| Hult Center for Healthy Living  |                         | Andrea Parker, RN, MS       | Executive Director                         |       |              |              | Holly Bill, MPH       | Assistant Manager   |                         |
| Human Service Center (a subsidiary of UnityPlace)   |                         | Dean Steiner, LCPC          | Acting Chief Operating Officer             |       |              |              | Stefanie Gidmark, MPH | Grant Supervisor  |                         |
| Tazwood Center for Wellness (a subsidiary of UnityPlace)  |                         | Dean Steiner, LCPC          | Acting Chief Operating Officer             |       |              |              | Stefanie Gidmark, MPH |   |                         |

| Entity Name             | Tax ID #<br>(xx-xxxxxx) | Primary Contact           | Position          | Email | Office Phone | Mobile Phone | Secondary Contact | Secondary Contact Position | Secondary Contact Email |
|-------------------------|-------------------------|---------------------------|-------------------|-------|--------------|--------------|-------------------|----------------------------|-------------------------|
| Tri-County Urban League |                         | Dawn Harris Jeffries, PhD | President and CEO |       |              |              |                   |                            |                         |
|                         |                         |                           |                   |       |              |              |                   |                            |                         |
|                         |                         |                           |                   |       |              |              |                   |                            |                         |
|                         |                         |                           |                   |       |              |              |                   |                            |                         |
|                         |                         |                           |                   |       |              |              |                   |                            |                         |
|                         |                         |                           |                   |       |              |              |                   |                            |                         |

3. Please confirm that you have entered the required information for each entity in the table above, including secondary contact information and Tax ID #.

☒ I confirm

4. Please upload the most recent IRS Form 990 (including Schedule H, if applicable) for all participants in the collaboration. (Note: These 990s will all have to be compiled into a single PDF file.)

YFBHC Proposal - Section 1. Participating Entities - Form 990s (all collaborators)

#### Participating Entities

#### Note on the centrality of collaborations to HTC:

Glossary of Key Terms - [Download Here](#)

*We believe that to truly transform health, patients' physical health, behavioral health and social needs must be addressed in a coordinated way within their community. Given this, we are looking for collaborations that represent a broad and meaningful spectrum of the healthcare, behavioral health and social determinants of health delivery system at the community-level.*

Form 1 Glossary of Key Terms.pdf

*Please answer the following questions regarding the various entities that would comprise your collaborative.*

1. Are there any primary or preventative care providers in your collaborative? *If you are unfamiliar with any key terms on this form, consult the glossary linked below*

☒ Yes  
☐ No

1A. Please enter the names of entities that provide primary or preventative care in your collaborative.

Methodist Medical Center

Heartland Health Services

University of Illinois College of Medicine Peoria

Hult Center for Healthy Living

2. Are there any specialty care providers in your collaborative?

☒ Yes  
☐ No

2A. Please enter the names of entities that provide specialty care in your collaborative.

Methodist Medical Center

Children's Home Illinois

Heartland Health Services

Human Service Center

Tazwood Center for Wellness

University of Illinois College of Medicine Peoria

3. Are there any hospital services providers in your collaborative?

☒ Yes  
☐ No

**Note: HFS is seeking to know in which MCO networks each hospital in your collaborative participates.**

3A. Please enter the name of the first entity that provides hospital services in your collaborative.

UnityPoint Health – Methodist Medical Center

3B. Which MCO networks does this hospital participate in?

- ☐ YouthCare  
☒ Blue Cross Blue Shield Community Health Plan  
☐ CountyCare Health Plan (Cook County only)  
☒ IlliniCare Health  
☒ Meridian Health Plan (Former Youth in Care Only)  
☒ Molina Healthcare

3C. Are there any other hospital providers in your collaborative?

- ☐ Yes  
☒ No

4. Are there any mental health providers in your collaborative?

- ☒ Yes  
☐ No

4A. Please enter the names of entities that provide mental health services in your collaborative.

Methodist Medical Center

Children's Home Illinois

Heartland Health Services

Human Service Center

Tazwood Center for Wellness

University of Illinois College of Medicine Peoria

5. Are there any substance use disorder services providers in your collaborative?

- ☒ Yes  
☐ No

5A. Please enter the names of entities that provide substance abuse disorder services in your collaborative.

Heartland Health Services

Human Service Center

Tazwood Center for Wellness

University of Illinois College of Medicine Peoria

6. Are there any social determinants of health services providers in your collaborative?

- ☒ Yes  
☐ No

6A. Please enter the names of entities that provide social determinants of health services in your collaborative.

Children's Home Illinois

Hult Center for Healthy Living

Tri-County Urban League

Human Service Center

7. Are there any safety net or critical access hospitals in your collaborative?

- ☐ Yes  
☒ No

8. Are there any entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that are majority controlled and managed by minorities?

- ☒ Yes  
☐ No

8A. Please list the names of the entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that are majority controlled and managed by minorities.

Tri-County Urban League.

The University of Illinois College of Medicine Peoria.

Hult Center for Healthy Living

9. Please list the Medicaid-eligible billers (firms that can bill Medicaid for services) in your collaborative, and the Medicaid ID for each.

UnityPoint Health – Methodist Medical Center

Children's Home Illinois

Heartland Health Services

Human Service Center

Tazwood Center for Wellness

University of Illinois College of Medicine Peoria

10. Below are high-level descriptions of project types that appeared in the Transformation funding statute. Check any that apply to your project; if none apply, please provide a brief description of what kind of entities comprise your collaboration. (This question is informational only and will not affect your eligibility).

- ☐ Safety Net Hospital Partnerships to Address Health Disparities  
☐ Safety Net plus Larger Hospital Partnerships to Increase Specialty Care

- ☒ Hospital plus Other Provider Partnerships in Distressed Areas to Address Health Disparities (led By Critical Area Hospitals, Safety Net Hospitals or other hospitals in distressed communities)
- ☐ Critical Access Hospital Partnerships (anchored by Critical Area Hospitals, or with Critical Area Hospitals as significant partners)
- ☐ Cross-Provider Care Partnerships Led By Minority Providers, Vendors, or Not-For-Profit Organizations
- ☒ Workforce Development and Diversity Inclusion Collaborations
- ☐ Other

10A. If you checked, "Other," provide additional explanation here.

N/A

[10A. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

**When you're finished answering the questions on this page, click [Mark as Complete](#). An application cannot be submitted until all pages are marked as complete.**

Not finished with this page yet? Click [Save](#) or [Save & Continue](#) to fill out the missing information at a later time.

## 2. Project Description

### HELP AND SUPPORT INFORMATION

**Note on work process:** We strongly recommend that applicants draft responses to long-form narrative questions locally (i.e. in Microsoft Word) and then copy and paste these responses into Amplifund. Many Amplifund response fields will preserve formatting (e.g. a table, bullet list, or text style) copied from word processing applications, allowing applicants flexibility in how they format their responses.

**If you need help or have a question:**

- For guidance on this form, consult the [HTC Application Instructions resource](#).
- If you have a question about the subject matter of the application, email [HFS.Transformation@illinois.gov](mailto:HFS.Transformation@illinois.gov) before October 15. Questions will not be taken after that date. Check for answers at the [HTC FAQs page](#), which will be updated continuously between October 1 and October 15.
- If you need technical support in Amplifund, email [support@il-amplifund.zendesk.com](mailto:support@il-amplifund.zendesk.com) with your question. All emails sent within business hours (7am-5pm) should receive a response within two hours.
- If you'd like to consult support resources provided by Amplifund: Visit the vendor's [support website](#) for user guides, tutorial videos, and other resources. You will have to register a new and separate account to access content on this site.

### Brief Project Description

1. Provide an official name for your collaboration. NOTE: Please ensure that this name matches the name given in the "Application Name" field in the Project Information form at the beginning of the application.

Youth and Family Behavioral Health Collaborative

2. Provide a one to two sentence summary of your collaboration's overall goals.

The Youth and Family Behavioral Health Collaborative ("YFBHC" or the "Collaborative"), comprised of community organizations, healthcare systems, and organizations of higher education serving Illinois' Peoria, Tazewell and Woodford Counties, aspires to develop and execute an integrated, evidence-based model of behavioral healthcare for children, adolescents and their families.

### Detailed Project Description

Provide a narrative description of your overall project, explaining what makes it transformational.

Specify your service area, identify the healthcare challenges it faces, and articulate your goals in addressing these challenges; explain your strategy and how it addresses the causes of these challenges, and lay out the expected timeframe for the project.

Describe any capital improvements, new interventions, delivery redesign, etc. Your narrative should explain the need for each significant item in your budget, clarifying how each connects to the overall goals and operations of the collaboration.

Provide your narrative here:

\*See attached file for pdf copy with full narrative, figures, and citations.

The YFBHC will provide a complete range of behavioral healthcare services to meet the needs of the area's families, including: greater access to care; comprehensive diagnostic and needs assessments in a welcoming and accessible centralized hub; synergetic and complementary direct and indirect services by an integrated team of practitioners; empirically-based treatments; a focus on social determinants of health and a unified approach to addressing markers of inequality (such as food insecurity, health illiteracy, cultural barriers to care, financial instability, and safe spaces for relaxation and physical exercise); attention to clinical and consumer-based outcomes; and, efforts to innovate in a manner that is specific to the community. Two key elements of the YFBHC will be to optimize community engagement and to develop a steady and reliable workforce. Community engagement efforts will include broad-based stakeholder input through all stages of planning and execution and will realize diversity and inclusion goals. On-site outreach services, such as in schools and in the neighborhoods, will help address issues of access while ensuring opportunities for the full range of comprehensive behavioral health offerings. The YFBHC will implement a pipeline recruitment program designed to expand and diversify the behavioral health workforce.

The goal of this Collaborative is to:

- Utilize patient centered, evidence-based approach to mental and behavioral health care in the community that integrates the best practices with compassionate and high-quality care.
- Implement a coordinated approach to management of community health mental and behavioral needs of the youth and children in the community.
- Design programs and evaluation criteria and partners with qualified community-based organizations to launch and study the impact of the pilots in the community.
- Develop and implement professional pipeline programs to aide in the development of a more robust and diverse workforce providing comprehensive mental and behavioral health services in the region.

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### Service Area:

The Youth and Family Behavioral Health Collaborative "YFBHC" or the "Collaborative") is focused on improving access to and delivery of child and adolescent behavioral health, mental health and substance abuse treatment services through transformative treatment facilities and programs in Peoria, Tazewell and Woodford counties (the "Tri-County Area"), which will specifically benefit the distressed areas in Peoria County and the high-risk zip codes 61603, 61604 and 61605.

### Healthcare Challenges:



Peoria County, specifically zip codes 61603, 61604 and 61605, are among the most distressed in the nation. The CDC Social Vulnerability Index measures Peoria County at 0.6131, indicating a moderate to high level of vulnerability. [i] Peoria's unemployment rate is higher than the state average and has been since 2013. [ii]

Source: [https://svi.cdc.gov/Documents/CountyMaps/2018/Illinois/Illinois2018\\_Peoria.pdf](https://svi.cdc.gov/Documents/CountyMaps/2018/Illinois/Illinois2018_Peoria.pdf)

Although there are many healthcare needs in Peoria and the surrounding counties, behavioral health care is one of great concern. When residents were asked about the area's most pressing health need as part of the 2019 Community Health Needs Survey ("CHNA"), 69% of survey respondents identified mental health as the most important health issue in the community. [i] Moreover, approximately 1/3 of respondents admitted they experienced depression or stress in the last 30 days. [ii] Nearly a tenth of the community, 8% of survey respondents, described their mental health as "poor," and only 28% of respondents stated that their mental health was "good." [iii]

Furthermore, in the Tri-County Area, 31.3% of 10th grade students indicated that in the past 12 months they felt sadness or hopelessness almost every day for at least 2 weeks, causing them to stop participating in some of their usual activities. 16.7% of 10th graders indicated they seriously considered attempting suicide in the past 12 months. [iv] Data from the 2018 Youth Survey measured illegal substance use among adolescents and found that Peoria County is at or above the state averages for substance use in all categories among 8th and 12th graders. [v] According to the National Institute of Mental Health ("NIMH") and National Alliance on Mental Illness ("NAMI"), delays in treatment contribute to the fact that 40% of students with mental illness drop out of high school. [vi] Those same organizations have reported that suicide is the second leading cause of death in children ages 10-34 years. [vii]

These mental health concerns are not surprising given the repeated and sustained trauma the youth experience. Systemic racism exists in this Community and impacts its youth. According to published school segregation data, Peoria area schools are more segregated than any other area in the state. [viii]

Source: Vock, D. and Maciag, B., *Still Separate After All These Years: How Schools Fuel White Flight*. January 19, 2019 (Available at: <https://www.governing.com/archive/gov-segregation-schools.html>)

Peoria also makes national headlines for its murder rate; CBS has listed Peoria as having the 15<sup>th</sup> highest murder rate in the country. [i] This is supported by the fact that the crime rate in Peoria for 2019 was 1.8 times higher than the U.S. average. [ii] From 2017 to 2019, the murder rate doubled. [iii] Homicide deaths also impact persons of color disproportionately. [iv]

Source: *Peoria County Mortality Report*, p. 21. (2019)

The children and adolescents in the community are exposed to this violence and the repeated trauma of their experiences can create mental health issues that need to be addressed to improve their well-being. This is compounded by the systemic racism that exists in the community and its impact on the youth. According to published school segregation data, Peoria area schools are more segregated than any other area in the state. [i] Peoria County struggles with poor school performance, demonstrated by low graduation rates and chronic truancy. [ii] But more troubling is the fact that the two leading causes of death for persons age 15-24 in Peoria County are homicide (52.9%) and suicide (11.8%). [iii]

Source: *Peoria County Mortality Report*, p. 10. (2019)

Despite recognizing the importance of their mental health, residents in the Tri-County Area are not seeking treatment. The 2019 CHNA revealed that Peoria County residents often choose not to seek medical care because of co-pay obligations, long wait times, lack of insurance and lack of transportation. The Institute of Medicine's Committee on Understanding and Eliminating Racial and Ethnic Disparities in Healthcare found that barriers that prevent or limit access to needed healthcare services may increase the risk of poor health outcomes and health disparities; this places marginalized communities, like Peoria County and other parts of the Tri-County Area, at a higher risk for developing health issues, despite our above-average availability of healthcare services. In fact, Peoria County ranks "Much Worse than Average" for overall adolescent health compared to the rest of the state. [i] Utilization of services is what drives positive health outcomes.

Identifying that physical and mental health are a problem in Peoria, and in response to recent protests about racial injustice, a council member (now the current mayor), and the former mayor, convened a group called the Healthcare Collaborative to address health equity. This group determined that the best way to understand the needs of the community is to engage the members of the community through conversation. To this end, focus groups for residents of the vulnerable zip codes of 61603, 61604, and 61605 were conducted on topics of colon cancer, cervical cancer, and mental health in both English and Spanish. These groups were led by trusted community members at community-based organizations. From this came further evidence of the desperate need for better behavioral health support for both children and adults. Specifically, concerns were voiced about the lack of providers people can afford, the wait times, the lack of providers of color, the lack of providers who listen, and other barriers to care such as transportation. Although these groups were held with adults, issues of child behavioral health arose as well, including the need for additional mental health providers and the trauma, including things like bullying that children and youth face.

The data and the community voices echo the Collaborators' own experiences. For example, at UnityPoint Health - Methodist ("Methodist Medical Center") 15.9% of all child and adolescent behavioral health admissions are for patients from the three target zip codes. Of those patients, 55.5% are racial minorities (Hispanic/LatinX, black/African American, multiracial). Of those patients seen in the mental health clinic, 27.4% come from the three target zip codes and 44.7% of those patients are minorities. Of the behavioral health evaluations performed on minors in the Emergency Department, 25% of the minors are from the three target zip codes, 51.5% of which are racial minorities. Although this data shows the clear utilization of mental health care, it is likely that this is just an underestimate, as behavioral health problems can often manifest as stomach aches, headaches, or other health conditions, that are not always clearly linked to a mental health problem. [i]

Additionally, in the last five years, that hospital had to turn away more than 2,600 children and adolescents in need of inpatient behavioral health, mental health, or substance use treatment due to lack of capacity, insufficient staff and not having resources to address the patients' acuity. The number of children turned away per year has been steadily increasing with 1,493 children and adolescents (approximately 500 per year) in 2016 to almost 600 children per year by 2020 due to lack of available beds or the patient's acuity exceeding hospital resources. The other two closest hospitals with child/adolescent AMI beds are in Springfield (75 miles away) or the Quad Cities area (90 miles away). The YFBHC seeks to fill these gaps so that patients requiring mental health services can receive quality, affordable care while remaining in their community, near their families and support systems. The distance needed to travel for care is particularly challenging for families without a vehicle, a common experience for those in living in the 61603, 61604, and 61605 zip codes where more than 13.21% of individuals do not own a vehicle. [ii] When mental healthcare for children and adolescents must be outsourced, families must make the difficult decision whether sending their child away is worth the treatment. Separating families during a mental health crisis adds to the stress and, for many, makes getting help seem impossible.

The data above present a clear need for more services, and, while there are individuals who would be able to provide some of these services, these practitioners have ended up leaving the area. Over the past eight years, 11 residents from the Psychiatry Training Program at the University of Illinois College of Medicine Peoria, who were interested in specializing in child and adolescent healthcare, had to go elsewhere to retrieve this advanced training because there is no Child and Adolescent Psychiatry Fellowship program

in the region. To keep up with the growing need, a local mental health training pipeline needs to be established in this region.

In addition to staffing and resource shortages, each of the Collaborators have encountered families and children in crisis who have expressed being overwhelmed by “the system” and who struggle to find the time, resources and strength to pursue all of the services needed to help their child heal, grow and succeed. The Collaborative encounters clients, patients and families who have been “turned off” and overwhelmed by the fact that they need to seek multiple therapies and treatment from different providers and entities in various locations. To successfully treat and recover from these illnesses, it is imperative that providers of behavioral health, mental health and substance abuse treatment develop a coordinated system that allows all families, regardless of income or race, to pursue coordinated, efficient, and quality services when necessary. No family should be forced into an extended period of crisis because of long wait lists and a lack of providers who do not accept their insurance. No child should have to continue to revisit their trauma by completing multiple similar assessments with new faces and different providers. And no parent should have to choose between their child’s healing and other financial obligations. This collaborative knows it can and must do more for children and adolescents in the community and proposes a transformational model that will make a meaningful difference in the lives of children and families in the Peoria and Tri-County Area.

#### **Plan to Address These Challenges:**

The YFBHC is the product of a larger Healthcare Collaborative initiative, which determined that mental health should be a priority for health equity based on the data gathered from the focus groups mentioned above. This subcommittee of the YFBHC was then formed to address this problem, and decided to prioritize the behavioral health of children and families as a first step. The YFBHC includes nine (9) agencies, including

- Unity Point Health, (a large healthcare system in the region with expertise in mental healthcare),
- University of Illinois College of Medicine Peoria (“UICOMP”) (regional campus for one of the largest medical schools in the country with strong academic expertise),
- Heartland Health services (an FQHC focused on care to the vulnerable population, PCCHD), and
- other community-based organizations that focus-on children and family services.

The objective of this collaborative is to create a unified, coordinated model of care that is focused on a community oriented, convenient family center and behavioral health hub that welcomes the community and its families and provides coordinated care and support for the Peoria-area youth, regardless of race, income or ethnicity. From this behavioral health hub, outreach work into the schools and other parts of the community will be coordinated. The emphasis is to help support the community where they live, learn, work and play, with a focus on both treatment and prevention. Furthermore, this hub and spoke model will also help address the needs of the community and population from a community-based approach across the continuum of care as outlined below.

Importantly, based on the feedback received from the community, the Collaborative will also address the social determinants of health and address access to care, healthcare literacy, and work force development.

#### **I. The YFBHC Will Develop and Implement a Transformational Coordinated Behavioral Healthcare Hub of Integrated Care**

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Based on the feedback and input from the focus groups, this proposal was developed to transform the current model for care delivery into a hub and spoke model designed to increase access to child and adolescent behavioral health care across the continuum, reduce inpatient readmissions, and implement outreach services and educational programs to improve health literacy. The hub will not only provide coordinated community services but also provide easy access to ambulatory and inpatient facilities so that patients can easily transition from one clinical context of care to another. Furthermore, these transitions in care will be effectively coordinated through the hub so that services ranging from counseling, support services for the family, family education and proactive education can be provided both in the hub and outreach in the community such as schools. As patients progress through the levels of service provided at and in the Hub, Collaborators can ensure improved participation for better outcomes. This hub model connecting the Collaborators will include:

- Family Navigators
- Shared common assessments, service plans, and tools
- Safe space and core physical hub for Child and Adolescent Behavioral Healthcare
- Integrated provider and agency coordination

##### **A. Family Navigators**

The collaborative will develop and implement a family navigator program to help patients and families establish and access the services they require. The YFBHC will recruit and train enough Family Navigators to provide at least one navigator for every 20 families who qualify for their services. (For high acuity clients, the ratio will be reduced to 1:12.) The Family Navigators will serve as a primary point of contact and a conduit to facilitate timely appointments, services, tools, and resources for appropriate and qualifying patients. For example, when confronted with insurance coverage issues, waiting lists and other issues that would otherwise prevent timely intervention and full engagement, the navigator can intervene and assist to keep the patient and family motivated, involved and engaged in the service plan. Navigators can also facilitate inter-provider meetings with patients and families when appropriate or necessary. The collaborative will develop the family navigator program to determine when to assign a navigator and when a patient and family no longer need a navigator having surpassed certain benchmarks.

As part of their training, the navigators will work with and become integrated with every agency’s programs, services, supports and processes in order to provide effective outreach and connect their families to the right resources at the right time based on current needs and/or obstacles. They will also receive compassion and implicit bias training, thereby ensuring they are equipped to work with all individuals and all circumstances.

##### **B. Shared Assessments, Service Plans and Tools**

Children who receive behavioral and mental health services often require multiple services and supports from various providers that serve different levels of acuity. Although a family navigator will help patients find the services they need, the Collaborators understand the need to improve the patient experience and minimize inefficiencies.

Patient experience is impacted by long wait times, patients typically undergo a long, uncomfortable assessment with each separate service provider. These repeated assessments delay the ability to initiate treatment and often force children to revisit traumatic experiences multiple times with multiple providers.

In an effort to reduce stress and streamline service planning across all providers, the Collaborative will develop and implement a single, comprehensive assessment that will be used by all providers. This endeavor will avoid wasted time, and resources and will improve patient and family engagement at an early stage. Family Navigators will also be trained on how to use the shared assessment to assist families with their social determinants of health ("SDOH").

Along with the shared assessment, the Collaborators will develop and implement a shared service plan tool so that the family navigator and all providers are aware of the services and supports that have been recommended, are being utilized, have been completed, are in progress or have been successful/unsuccessful. By accessing this information, each provider can understand how their services and supports fit into the patient's healing map and how their health journey is impacted by various SDOH. Clinicians, therapists, and counselors should know what other services are in place for the patient – but they should also know if the patient is receiving services in school or assistance with residential placement or food insecurity. When providers have more information about the patient's needs, they can better meet the patient where they are and help the patient take the next best step given other challenges and obstacles they are facing at that time.

The final piece to improve outcomes will be the Collaborators adoption of empirically supported treatment approaches. In so doing, providers will employ approaches proven to effect positive patient results across a broad range of behavioral health problems. By adopting common treatment platforms, providers and patients will speak a unified language, allowing seamless movement within system and across the continuum of care. Patients and families will be empowered to advocate for themselves and develop more sustained independence through familiarity of language and treatment goals. For example, for individuals suffering from traumatic events, the Collaborators may guide providers to follow approaches advocated by the National Council for Behavioral Health's Trauma-Informed, Resilience-Oriented Approaches.

### ***C. Safe Space and Core Physical Hub for Child and Adolescent Behavioral Services Across the Healthcare Continuum.***

At the core of this proposal is a new, state-of-the-art, child and adolescent behavioral health facility that will provide essential resources and space for skilled area providers to serve children and families in one welcoming, convenient, and central location. This "Hub" will be home to both inpatient and outpatient mental health, behavioral health and substance use treatment, therapies, and resources. Expansion of space will allow the Collaborative to continue to provide services to all individuals regardless of payor source, including providing Medicaid-covered services as well as low- and no-cost services.

In addition to the inpatient psychiatric services provided at the proposed center, there will be embedded outpatient and primary care offices to provide a full continuum of mental health and substance use care for children, adolescents, and their families. Presently, UnityPoint Health – Central Illinois operates a 23-bed child and adolescent unit within Methodist Medical Center in Peoria, Illinois. This unit is part of the region's most comprehensive continuum of care for behavioral health and has served tens of thousands of children over the past 30 years. The current child and adolescent unit is located on the 8<sup>th</sup> floor of Methodist Medical Center and was built in 1917. In 1988, the building was renovated to include the current child and adolescent unit. Since that time, only repairs to the unit have been completed.

Due to limited space in the existing unit, 23 beds are not enough to accommodate the demand for services. And the unit's design – a long hallway within a hospital setting, with no way to segregate high acuity patients – is not conducive to current treatment modalities. This is one of the reasons more than 2,600 children were denied services since 2016.

Building a new and larger center will serve Illinois' children, adolescents and their families through increased bed capacity, increased flexibility to address acuity and diagnostic concerns, integration of inpatient and outpatient services, and coordination of physical and mental health services.

The inpatient center will bring necessary, updated improvements to the care provided to Tri-County residents in the form of:

- Expanded overall bed capacity from 23 to at least 43 adolescent behavioral health beds
- Improved access to treatment services by doubling the number of skilled psychiatrists and counselors
- The first unit specializing in the care of children with Autism and Asperger's
- The region's first behavioral health ICU to accommodate high acuity patients
- A new intensive outpatient program to reduce inpatient admissions
- A 24/7 crisis center to avoid unnecessary Emergency Department visits
- Recreational and experiential spaces including, recreational/exercise space, art therapy, music therapy and a sensory room to provide alternative forms of healing and treatment
- Space for support groups for children and parents
- Different "neighborhoods" for children and adolescents, with adolescents separated by gender.

The Hub will also be home to a new Intensive Outpatient Program ("IOP") to provide higher acuity services daily and in an outpatient setting. IOP's for adolescents typically provide three hours of therapy after school — providing crucial intervention and support services in a nurturing environment while allowing the child to continue with their traditional school day and remain in their home environment overnight. The IOP program will focus on dialectical behavior therapy ("DBT"), a comprehensive, evidence-based treatment. There is currently no such program offered in the Tri-County Area, and an IOP program will allow area providers to provide essential treatment and services without inpatient admissions and avoiding costly, wasteful Emergency Department visits.

The adjacent outpatient and community center will provide a comfortable, convenient, positive, and trusted space for families and children to see providers, counselors, therapists, and other service providers (individually and in group sessions) in one convenient location. Childcare, transportation services and other essential services will be offered to help families overcome the barriers that too often block access to care and detract from patient engagement. The center will also provide space where families can receive social services, support and advice that is a critical piece in the treatments, therapies and services provided at the Hub. For example, the outpatient center will serve as the "home base" for the Family Navigators and will be staffed with trained concierge receptionists who can help refer inquiring families to resources. The center will offer spaces and offices for families to receive behavioral health supports and services from Collaborators and other community partners. The center will also host support groups, health fairs, food drives, and education seminars for community families and youth.

By locating the outpatient center immediately adjacent to the child and adolescent inpatient center, children, adolescents, and their families will benefit from earlier and greater cooperation and coordination between inpatient and outpatient services and aid in a smooth transition between care levels. By introducing and connecting patients and their families to outpatient providers and necessary community services while receiving inpatient care in the same building, the Collaborators can surmount the social determinants of health that create obstacles to successful transitions, outpatient engagement and persistent healing. Through improved care coordination, the transition from

inpatient to outpatient care will be optimized, better connecting youth and families with appropriate services that meet their needs.

This Hub model will be specifically built and designed to support increased access to child and adolescent behavioral health care, reduce inpatient readmissions and improve student outcomes by expanding access to quality, high-acuity care in the community. As patients progress through the levels of service provided at and in the Hub, Collaborators can ensure improved participation for better outcomes.

#### ***D. Integrated Agency Coordination***

Finally, by developing the Collaborative, these related service and healthcare providers will necessarily come together and meet regularly to:

- Facilitate ongoing conversations between organizations to identify gaps in services and care and develop a coordinated approach to enhance patient care services.
- Facilitate opportunity for bidirectional conversations between the health care navigators and the collaborators on challenges and needs for the patients.
- Provide a forum for education of the family navigators on available resources in the community
- Create a shared repository of community resources that can be made available to the healthcare systems and the community.
- Foster structured communication and coordination of referrals for the benefit of Tri-County area's children and family.
- Develop and streamline processes to enhance efficiency and ensure consistency in the patient education.

### **II. The Collaborative will Expand their Integrated Care Model into the Community and Schools**

With increased coordination, more efficient care delivery and more counselors, therapists, and professionals, each of the Collaborators will be able to develop more robust, proactive outreach programs and deliver their services to the Peoria-area schools and the community. This will bring the resources to where our vulnerable populations learn, providing the tools that can help them cope in stressful situations and view others with compassion. Empowering teachers with much-needed developmental and technical support to address the emotional difficulties facing children today will expand the impact.

Each collaborator already has well-developed community-based programs and services that each delivers to the community. Utilizing shared resources in the form of navigators, shared assessments, shared service plans and evidence-based programming, the YFBHC can become more efficient. The implementation of navigators will free up counselors and therapists to focus on counseling and therapy, rather than appointment planning and referrals. Shared assessments and service plans will allow each entity to receive critical background information and allow services to begin at the first appointment instead of the second or third. These increased efficiencies will increase the Collaborators capacity to do more of what they do best such as:

- Growing the number of Safe Zones and safe spaces for those identifying as LGBTQ+, in partnership with community partners, such as Central Illinois Friends and Hult Center for Healthy Living.
- Providing trauma-informed education and training to increase number of trauma-responsive schools in community in partnership with community partners, such as local Regional Offices of Education and Lifting Up, LLC (a software tool to automatically generate notification among first responders and schools when a child experiences an adverse experience at home).
- Increasing social-emotional learning among the Tri-County area's youth.
- Expanding suicide prevention and awareness programming.

The University of Illinois College of Medicine Peoria's Center for Wellbeing will expand its current efforts into the Peoria Public Schools and other area school districts. Evidenced based programs for teachers and administrators, such as Emory University's Social, Emotional and Ethical ("SEE") Learning workshops will be provided to extend the impact from teachers to students and families. Educational services will be provided to students in areas such as compassionate self-care, health literacy, improving resiliency, anti-bullying, conflict resolution, and effective communication. A pilot model for these and other Center for Wellbeing services has been successfully implemented in a local school in a manner that is easily adaptable and scalable. Hult Center for Healthy Living will similarly be able to increase the number of Peer Educators in Peoria high schools using NASPA's Certified Peer Educator training; Peer Education is an evidence-based practice to improve health education outcomes, adopt health promotion and prevention behaviors, and increase access to health-related resources. Children's Home can expand its mental health work in the Community and in schools by being able to refer to and utilize the Collaborative's outpatient psychiatric services. Many families are reluctant to work with providers who do not have the capability of involving psychiatry services. Through this Collaborative, no family will be forced to "shop around" for providers that are able to meet most of their needs. Instead, this Collaborative will allow families to work with a unified group and that can, collectively, meet all their needs in an efficient, coordinated way.

The YFBHC believes collaboration between health care providers is a key strategy for improving patient outcomes and facilitating reform. This collaborative has been designed to embody the critical elements for a successful collaborative: accountability, communication, leadership, coordination, a shared, clear purpose, and a defined strategy. The YFBHC believes its participation in the Illinois Healthcare Transformation Program provides an extraordinary opportunity to reform and improve access and engagement, but also revolutionize the health and welfare of Peoria and Tri-County Area children and families.

### **III. The YFBHC will Develop a Sustainable Professional Pipeline to Deliver this Integrated Care**

With a state-of-the-art facility that re-envisioned how child and adolescent behavioral health care is delivered, and the hub and spoke model to grow community engagement and outreach, this collaborative can attract more clinical professionals to better serve the area's needs. To ensure recruitment of clinicians, counselors and therapists that accept Medicaid, the Collaborative seeks to develop and implement a paid internship program to attract a diverse pipeline of therapists and counselors from nearby colleges and universities to serve Peoria-area children and families in Peoria.

The Collaborative's governing body will facilitate a process by which the Collaborative will identify areas where additional providers and counselors are most needed to achieve the goals and outcomes of the Collaborative and distribute transformation funds to those entities to recruit and hire those positions with a preference for diverse

persons and professionals that are a reflection of the Peoria-area community. To accomplish this, the Collaborative will develop specific initiatives to incentivize minority participation and those underrepresented in the healthcare community to increase diversity among behavioral health providers in the Peoria area.

Those funds distributed for paid internships will create a career path for local persons and students to receive the education and training to become behavioral health therapists, counselors and other professionals while accomplishing the goals of this collaborative and creating a formal pipeline for local college students to build a professional network and career in Peoria County.

The YFBHC will also support the development of a child and adolescent psychiatry fellowship. This Accreditation Council for Graduate Medical Education (“**ACGME**”)-Certified training program will form a key pipeline for the development and recruitment of child and adolescent psychiatrists. The two-year fellowship, the first of its kind in the region, will be an extension of the already successful general psychiatry residency training program. The general training program, founded in 2011, illustrates the positive results inherent to the strong partnership between UnityPoint Health and the University of Illinois College of Medicine Peoria (“**UICOMP**”). The program has been able to recruit more than three dozen medical students from more than 20 schools across the nation to train in Peoria. The program has prepared 11 graduates for advanced training in child and adolescent psychiatry, but because there are no fellowships in Peoria, these graduates have sought training elsewhere. A new YFBHC’s child and adolescent psychiatry fellowship will be an attractive recruitment vehicle for adding the requisite UICOMP faculty members, while adding service through relatively low-cost trainees. Most important, the creation of a fellowship program will serve as a pipeline for recruitment of graduate trainees. Trainees interested in this field will have the opportunity to continue their training and forge professional relationships in their local community, thereby increasing the probability that these homegrown physicians will remain in the Tri-County area.

Finally, by developing a new, state-of-the-art, coordinated system of care across all provider types, the Collaborators believe this transformational program will better attract and retain professionals who are willing to invest their careers in Peoria and are willing to deliver high-quality, Medicaid-covered care in an environment that fosters efficiency, collaboration and opportunities for research.

### Timeframe

Recognizing the significant time necessary to bring the Hub into operation, the Collaborative has devised a multi-phase approach to implementing its plan. (A detailed timeline is illustrated in Section 14, below). If this proposal is approved, the Collaborative will develop the steering committee, prepare and execute an affiliation agreement, develop its charter and begin meeting before any funds issue. This preparatory work will allow the Collaborators to begin implementing the proposal program towards its goals on the first month of funding.

The Collaborative has set the following schedule for each element in its proposal:

- Family Navigator Program
  - Months 1-5: Develop program metrics and benchmarks (Months 1-5)
  - Months 6-9: Recruit Family Navigators (Months 6-9)
  - Months 9-12: Train Family Navigators (Months 9-12) *\*to coincide with shared assessment being completed*
  - Beginning Month 12: Implementation of Family Navigator Program
- Shared Practice Tools
  - Months 1-3: Purchase evidence-based practice
  - Months 4-6: Train personnel on evidence-based practice
  - Months 7-10: Develop shared assessment tool
  - Months 9-12: Develop shared service plan
  - Beginning Month 12: Implementation of evidence-based practices and shared tools
- Internships
  - Months 1-6: Planning (identify positions and quantity)
  - Months 4-12: Recruiting
  - Beginning month 10: Implementation of interns
- Fellowship Program
  - Months 1-12: Recruit core faculty, develop fellowship program and apply for accreditation
  - Months 13-16: Waiting period for approved accreditation
  - September 1 following receipt of accreditation: Fellowship recruitment begins (Fellowships follow a standard annual cycle will recruiting occurring from September – January each year. Fellows are selected in January and the Fellowship begins on July 1 each year).
- Program Evaluation
  - Months 1-6: Baseline data collection
  - Months 6-9: Baseline data analysis
  - Months 10-12: Baseline results reporting
  - Months 13-14: Data acquisition begins
  - Months 15-16: Data analysis begins
  - Months 17-18: Dissemination, discussion and review of data begins
  - Acquisition, analysis and dissemination will occur every six months
- Family Hub and Community Center
  - Months 1-3: Purchasing/Closing on property
  - Months 2-5: Design
  - Months 5-7: Bids
  - Months 5-9: Permits
  - Months 9-23: Construction
  - Months 22-24: Licensure, Certifications, Occupancy and other Approvals
  - Month 25: Opening of Hub and Community Center.

Once construction is completed, which is planned for Month 25, the Collaborative will then bring the implemented services and programs into the Hub for full implementation of the Collaborative’s plan.

Within the first year of funding, the Peoria-area will benefit from additional therapists, counselors, and Family Navigators coordinating services and supports from a central location and a coordinated system of care both in the Hub and reaching into the community and schools to capture those in need.

[i] Agency for Toxic Substances and Disease Registry, *Social Vulnerability Index*, Ctrs. for Disease Ctrl., (Oct. 9, 2018), <https://svi.cdc.gov/map.html> [hereinafter "*Social Vulnerability Index*"].

[ii] Partnership for a Health Community, *Community Health Needs Assessment 2019*, at 22, <https://www.pcchd.org/DocumentCenter/View/705/2019-Tri-County-Community-Health-Needs-Assessment-PDF-> [hereinafter "CHNA"]

[i] Helen Link Egger, E. Jane Costello, Alaattin Erkanli, Adrian Angold. *Somatic Complaints and Psychopathology in Children and Adolescents: Stomach Aches, Musculoskeletal Pains, and Headaches*, *Journal of the American Academy of Child & Adolescent Psychiatry*, Volume 38, Issue 7, 1999, Pages 852-860, ISSN 0890-8567, <https://doi.org/10.1097/00004583-199907000-00015>.

[ii] See PolicyMap (last accessed Nov. 15, 2021), <https://www.policymap.com/newmaps#/>.

[i] *Illinois Adolescent Health County Rankings*, Illinois Dept of Public Health Office of Women's Health and Family Services, (Oct. 2020), <https://dph.illinois.gov/content/dam/soi/en/web/idph/files/publications/adolescent-health-county-ranking-short-summary-maps-v2.pdf>

[i] *Id.*

[ii] *Id.*

[iii] *Id.* at 10.

[i] Fieldstadt, E. *Murder Map: Deadliest U.S. Cities*, CBS News, (Apr. 19, 2021 3:47pm), <https://www.cbsnews.com/et-pictures/murder-map-deadliest-u-s-cities/?tag=ACQ0534a8f&fbclid=IwAR1S6frKrGhW-eMz2H8lc7b8ViMDOOtwsrSf-stEcRjmb2-YDpsTP1aSSy>.

[ii] *Crime Rate in Peoria, Illinois (IL): Murders, Rapes, Robberies, Assaults, Burglaries, Thefts, Auto Thefts, Arson, Law Enforcement Employees, Police Officers, Crime Map*, City-Data.com, (last accessed Nov. 15, 2021), <https://www.city-data.com/crime/crime-Peoria-Illinois.html> [hereinafter "*Crime Rate in Peoria, IL*"].

[iii] *Peoria County Mortality Report 2019*, Peoria City/County Health Dept., at 21, <https://www.pcchd.org/ArchiveCenter/ViewFile/Item/660>.

[iv] *Id.*

[i] *Id.* at 75.

[ii] *Id.* at 50.

[iii] *Id.* at 49.

[iv] *Id.* at 81.

[v] *Id.* at 51, 57.

[vi] *To Assure the Free Appropriate Public Education of All Children With Disabilities (Individuals with Disabilities Education Act, Section 618) Twenty-Third Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act, 2001*, US Dept. of Educ., (Mar., 2002), <https://files.eric.ed.gov/fulltext/ED466918.pdf> [hereinafter "*23<sup>rd</sup> Annual Report to Congress*"].

[vii] *Mental Health By the Numbers*, Nat'l. Alliance on Mental Health, (Mar. 2021), <https://www.nami.org/mhstats> [hereinafter "NAMI"].

[viii] Vock, D.C. and Maciag, M., *Still Separate After All These Years: How Schools Fuel White Flight*, *Governing*, (January 19, 2019), <https://www.governing.com/archive/gov-segregation-schools.html>.

[Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

FINAL - Youth and Family Behavioral Health Collaborative - FY 2021-22 Proposal (80820375v1)-c

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### 3. Governance Structure

#### HELP AND SUPPORT INFORMATION

**Note on work process:** We strongly recommend that applicants draft responses to long-form narrative questions locally (i.e. in Microsoft Word) and then copy and paste these responses into Amplifund. Many Amplifund response fields will preserve formatting (e.g. a table, bullet list, or text style) copied from word processing applications, allowing applicants flexibility in how they format their responses.

**If you need help or have a question:**

- For guidance on this form, consult the [HTC Application Instructions resource](#) and the [HFS Guide to Collaborations](#).
- If you have a question about the subject matter of the application, email [HFS.Transformation@illinois.gov](mailto:HFS.Transformation@illinois.gov) before October 15. Questions will not be taken after that date. Check for answers at the [HTC FAQs page](#), which will be updated continuously between October 1 and October 15.
- If you need technical support in Amplifund, email [support@il-amplifund.zendesk.com](mailto:support@il-amplifund.zendesk.com) with your question. All emails sent within business hours (7am-5pm) should receive a response within two hours.
- If you'd like to consult support resources provided by Amplifund: Visit the vendor's [support website](#) for user guides, tutorial videos, and other resources. You will have to register a new and separate account to access content on this site.

**Note on the significance of governance structure:**

We recommend you consult the [HFS Guide to Collaborations](#) for your reference as you develop your governance structure.

*The governance section should reflect serious thought regarding the execution, management, accountability, and inter-reliance of the participating members of your collaboration. It should be clear how the structure and governance will bind the various participating organizations into an interrelated enterprise to accomplish the scope of work and the promised outcomes of the proposal. A well-developed governance process is the engine that will drive the effective implementation of the project. Absent quality governance, great ideas and good intentions often fall short or fail altogether*

#### Structure and Processes

1. Please describe in detail the governance structure of your collaboration and explain how authority and responsibility will be distributed and shared. How will policies be formulated and priorities set?

The Youth and Family Behavioral Health Collaborative ("YFBHC") will be governed by an affiliation agreement executed by each collaborating entity. The affiliation agreement will outline the authority and responsibility of each collaborating entity and include detailed commitments from each entity in relation to: (1) the entity's adherence to the YFBHC's policies; (2) the entity's agreement to diligently pursue and achieve objectives of the Collaborative; and (3) the entity's agreement to engage in honest dealing and to act prudently, ethically, and in good faith in all respects pertaining to the Collaborative.

The affiliation agreement will include and/or address staffing commitments from each collaborating entity (including, without limitation, titles and job descriptions of employees assigned to the Collaborative and weekly hour commitments), in kind resource commitments, and representations that each entity has certain required written policies in place (including, without limitation, policies pertaining to non-discrimination, sexual harassment, diversity, training, ethics, and record-keeping and reporting) and that the entity has the authority to enter into, and be bound by, the affiliation agreement.

The YFBHC will be governed by a Steering Committee composed of two (2) representatives from each collaborating entity (one of which will be a clinical representative, e.g., a physician, if available), and three (3) at-large community members (two of which shall be patients/clients or family members of patients/clients of one or more of the collaborating entities). A charter will be developed to guide the responsibilities and duties of the Steering Committee. The Steering Committee will meet weekly for the first three months and at least monthly thereafter based on needs unless greater frequency is desired.

The Steering Committee will:

- Develop written policies, including those related to the timely distribution of funds, and set ongoing priorities and/or objectives for the Collaborative
- Set and review ongoing priorities and/or objectives for the Collaborative
- Provide oversight of the fund distribution to ensure that it is aligned with the goals of the Collaborative and needs of the community, including determining when to hold town halls or other events to get additional community input
- Review on an ongoing basis the expenses and use of the allocated dollars
- Examine the reports of the success of the programs and discuss solutions where problems exist

[1. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

#### Accountability

2. How will collaborating entities be made accountable for achieving desired outcomes? How will the collaboration be made accountable for acting prudently, ethically, legally, and with extensive participation from each participating entity? What methods will be used to enforce policy and procedure adherence?

In the event a collaborating entity fails to honor its commitments, materially breaches the affiliation agreement, or violates a written policy of the YFBHC, the collaborating entity will be subject to penalties as determined by the Steering Committee, including, among others, termination from participation in the Collaborative, relinquishment of the entity's potential "right" to receive transformation funds, and repayment of any funds received prior to the collaborating entity's termination. Furthermore, the inclusion and involvement of at-large community members will reinforce community needs and bring the community's voice to the Collaboration to ensure those needs are heard and considered.

[2. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

#### New Legal Entity

3. Will a new umbrella legal entity be created as a result of your collaboration?

- ☐ Yes  
☒ No

[3A. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

#### Payments and Administration of Funds

**Note: It is likely that transformation funds for proposals will come in the form of utilization-based Directed Payments to a healthcare provider(s) or behavioral health provider(s) in the collaboration. These entities will receive a report earmarking these payments as transformation funds. These funds must then be distributed among the collaborating entities.**

4. How will you ensure direct payments to providers within your collaboration are utilized for your proposed program's intended purpose? If the plan is to use a fiscal intermediary, please specify.

The YFBHC proposes that directed payments be distributed to Methodist Medical Center of Illinois and subsequently distributed by Methodist Medical Center of Illinois to collaborating entities in accordance with the YFBHC's written policy on the distribution of funds, as adopted by the Steering Committee, and previously approved budgets. The Steering Committee will regularly review the receipt of funds by Methodist Medical Center of Illinois, along with subsequent disbursements made to collaborating entities, to ensure appropriate uses of the funds and compliance with previously approved budgets and objectives of the YFBHC. Collaborating entities will be required to submit monthly reports to the Steering Committee detailing expenses and uses of the funds.

[4. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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#### 4. Racial Equity

##### HELP AND SUPPORT INFORMATION

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**If you need help or have a question:**

- For guidance on this form, we especially recommend reviewing the recording of the 9/30/21 Informational Webinar (accessed via the HTC [Application Information](#) page) in which the racial equity section received extended explanation. You may also consult the [HTC Application Instructions resource](#) and HFS' [Racial Equity Impact Assessment Help Guide](#) posted on the HTC website.
- If you have a question about the subject matter of the application, email [HFS.Transformation@illinois.gov](mailto:HFS.Transformation@illinois.gov) before October 15. Questions will not be taken after that date. Check for answers at the [HTC FAQs page](#), which will be updated continuously between October 1 and October 15.
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##### Background on HTC and racial equity:

*This form contains a racial equity impact assessment, or REIA. An REIA is a systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision. REIAs are used to minimize unanticipated adverse consequences in a variety of contexts, including the analysis of proposed policies, institutional practices, programs, plans and budgetary decisions. The REIA can be a vital tool for preventing institutional racism and for identifying new options to remedy long-standing inequities. (Source: Race Forward - "[Racial Equity Impact Assessment](#)")*

##### High-Level Narrative

A fundamental focus of healthcare transformation is racial equity. Please provide a high level description of how the design of your proposal incorporates racial equity. (Greater detail will be requested in the questions below.)

Civil unrest in Peoria in the wake of the killing of George Floyd prompted Peoria's mayor and a local Councilwoman to convene a racial justice and equity coalition to identify opportunities to address and improve racial justice and equity in the community. This early effort led to the creation of the Joint Commission on Racial Justice and Equity. The Joint Commission's mission is to accelerate efforts to institutionalize racial justice and equity within county and city government and to advance its adoption throughout the region. One of the focused groups that emerged from this was the Healthcare Collaborative. The membership of this Collaborative includes leadership from UICOMP, Unity Point Health, OSF HealthCare, Heartland Health Service, Advanced Medical Transport of Central Illinois, and the Peoria City and County Health Department. Since then, this has grown to include Bradley University, the YMCA, and other community-based organizations. The YFBHC evolved out this Healthcare Collaborative to identify opportunities to address and improve racial justice and equity in the community with a specific focus on mental and behavioral health.

Building on this core value, the YFBHC is committed to focusing attention on developing practices and policies to address and combat racial inequities that exist in and around the delivery of care for patients with mental and behavioral health issues. Communities of color experience a disproportionate amount of trauma and attendant depression and anxiety due, at its roots, to structural racism. The Black/African American and Hispanic/Latinx communities experience more poverty, more violence, more discrimination, less education, and overall, more stress. Challenges identified by the residents of these communities in the focus groups conducted by the healthcare collaborative include a lack of education/knowledge of resources, the need for providers who are relatable and listen, the need for support groups, the lack of psychiatrists for children, the long wait times for care, the need of inpatient facilities, and the daily stress that these communities experience. In Peoria, there is a strong overlap between poverty, lack of transportation, and where people of color live.<sup>[1]</sup> A coordinated community care Hub, placed in the center of the most-vulnerable, most-impacted at-risk communities that will reach out to meet patients where they are will bring much-needed direct and coordinated mental health care to the children and families who need it most.

This initiative will help:

- 1) Coordinate and centralize the intake and support for children and families struggling with behavioral health issues by providing a pointed access to health care hub that includes an easily accessed physical space, services and support that can be reached by socioeconomically disadvantaged communities
- 2) Provide health literacy education through the community outreach programs that can help demystify the barriers and stigma associated with mental health
- 3) Expand outreach to the schools to provide support for teachers and students to enhance resilience/compassion and decrease bullying.
- 4) Develop a common curriculum for educating community members, law enforcement and first responders about what to do in the event of mental health crisis
- 5) Expand and diversify the mental health workforce in Peoria to help support patients of color and Latinx community
- 6) Develop a pipeline for future mental health providers through implementing internships and other educational programs in high school especially in the vulnerable zip codes of 61603, 61604, 61605
- 7) Provide a forum to continually engage with the at-risk communities through community conversations to gather feedback on the programs, and develop a shared understanding of their ongoing healthcare needs and services

By making mental healthcare no longer something of privilege, but rather something that everyone can access, disparities will be reduced. Further, teaching children resilience and compassion alongside health promotion and prevention programs in the schools will reduce discrimination, address health disparities, and help bring the younger generation one step closer towards equity.

[1] See PolicyMap (last accessed Nov. 15, 2021), <https://www.policymap.com/newmaps#/>.

you must combine them into a single document.)

## Racial Equity Impact Assessment Questions

### 1. Which racial/ethnic groups may be most affected by and concerned with the issues related to this proposal?

Mental illness knows no boundaries and has no barriers. It impacts the lives of all people, regardless of the color of their skin, ethnicity, or cultural or socioeconomic background. However, the Collaborators recognize and experience that communities of color experience a disproportionate amount of trauma due to violence, poverty, and systemic racism in their communities. [i] All of this, in turn, presents mental health challenges that are not as prevalent in the Caucasian population. COVID-19 has disproportionately impacted these communities creating additional mental health concerns, as seen both in the data of morbidity and mortality, but also as mentioned as a concern by community members in the focus groups. [ii] As one member of a Black/African American focus group put it, “[The pandemic] happened so fast, so fierce, so hard, people dying around you.” And even for individuals who have not experienced a loss due to COVID-19, additional burdens come from the need to homeschool children, job loss, and added stress, which disproportionately impact people of color. Furthermore, communities of color have far less access to services and supports to address that trauma due to a lack of low-income providers, long wait times, insufficient Medicaid-covered resources, lack of transportation and a lack of knowledge about what services and supports are available. The coordinated community care Hub providing low- and no-cost services, placed in the center of these most-impacted at-risk communities that will reach out to meet patients where they are will bring much-needed direct and coordinated mental health care to the children and families who need it most.

[i] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Roundtable on Population Health Improvement, *Community Violence as a Population Health Issue: Proceedings of a Workshop*, Nat’l Academies Press, (Jan. 17, 2017), at 2, <https://www.ncbi.nlm.nih.gov/books/NBK441708/>.

[ii] *COVID Data Tracker: Demographic Trends of COVID-10 Cases and Deaths in the US Reported to CDC*, Ctrs. for Disease Ctrl., (Nov. 14, 2021), <https://covid.cdc.gov/covid-data-tracker/#demographics>

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

### 2. Have stakeholders from different racial/ethnic groups — especially those most adversely affected or from vulnerable communities — been informed, meaningfully involved and authentically represented in the development of this proposal? Who’s missing and how can they be engaged?

Yes. This collaborative has convened focus groups and engaged with community members from the Tri-County Area from all racial backgrounds and socioeconomic groups to identify the obstacles and barriers to healthcare that are specific to vulnerable, low-income community members and racial minorities. The focus groups and meetings allowed participants to discuss their experiences, their concerns, and the challenges they face freely and openly. Some of the main concerns voiced by the community members included a lack of providers who were relatable, the need for providers who will listen, the stigma around mental health, the need for support groups, the lack of follow-up for patients released from the hospital, the lack of resources in schools, the stress that leads to mental health problems, and the trauma experienced around COVID-19 and death. The feedback from these groups provided clear direction to this collaborative for what obstacles and barriers need to be addressed to increase access and engagement to the target population.

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

### 3. Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed?

Peoria County and the target zip codes have a high concentration of residents who are people of color in the region. That same area also has the most residents with income at or below the poverty level and who lack of transportation. [i] These factors converge to create a substantial barrier that disadvantages the community, which disproportionately disadvantages persons of color. When adequate behavioral healthcare is not available in an accessible way, those without resources are left without the means to get help. Additionally, the stress of living in poverty and sometimes having to work multiple jobs to support children leaves people living in poverty with very little time to access mental healthcare for themselves or their children, and when the services are not coordinated, it is almost impossible to find the time to go to one agency, then go to a second one and repeat the same story.

At Methodist Medical Center, 15.9% of all child and adolescent behavioral health admissions are for patients from the three target zip codes. Of those patients, 55.5% are racial minorities (Hispanic/Latinx, black/African American, multiracial). Of those patients seen in the mental health clinic, 27.4% come from the three target zip codes and 44.7% of those patients are minorities. Of the behavioral health evaluations performed on minors in the Emergency Department, 25% of the minors are from the three target zip codes, 51.5% of which are racial minorities. More affluent portions of the Tri-County Area, which is also predominantly white, tend to have more money, reliable transportation, commercial insurance with access to more specialty providers, and employment with more schedule flexibility and/or one stay-at-home parent who is able to coordinate multiple services. Additionally, these areas also experience less food insecurity, less violence, increased safety, and more access to childcare services. Thus, coordination between a counselor and a food pantry is irrelevant for the more affluent portions of the Tri-County Area but may be critical for the less affluent regions.

Third, Peoria County and the target zip codes experience exponentially higher violence rates and the children in those areas are far more likely to experience and observe trauma related to violence. [ii] Furthermore, when children know the victim, perpetrator, or live close to where the violence occurred, their behavioral and mental health needs are more acute.

Access to affordable care, providers that listen, providers look like their patients, support groups, and improvement of knowledge/health literacy are of paramount importance to communities of color in Peoria and this was confirmed in the focus groups run among residents of 61603, 61604, and 61605. This proposal is designed to ensure that the individuals living with the most trauma and the least resources have access to the care and support they need in their own community.

Currently, little is known about the relative levels of mental health issues broken down by racial/ethnic group and the rates at which they can seek care, particularly outpatient treatment. Unfortunately, these data for adults and children is not readily available. While the Collaborators know that all the factors that lead up to mental health issues (poverty, violence, discrimination) are higher in minority populations, the Collaborators do not know the entire extent to which mental health issues have impacted these populations. Part of this proposal will include a comprehensive epidemiologic survey to get a more concrete measurement of these numbers.

[i] PolicyMap, supra note xv.

[iii] See e.g., *Peoria County Mortality Report 2019*, supra note xiii, at 20.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

4. What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise? Are they expanding or narrowing? Does the proposal address root causes? If not, how could it?

Historically, people of color have suffered various forms of structural oppression that has resulted in minority communities having less education, fewer job options, unsafe housing (and lack of access to the funds needed to rent or buy homes), more violence, lack of safe spaces to exercise, lack of grocery stores for nutritious food, and consistent discrimination. These foundational disparities create the obstacles that stand in the way of healthcare access (i.e. transportation, insurance coverage, financial resources for co-payments, time to attend appointments, ability to understand how to access and engage with providers, etc.).

While this proposal cannot address all these issues and eliminate the root cause of structural racism, it can develop and implement programs to remove the barriers that prevent equal access to quality behavioral and mental health care. This proposal will ensure that the community in which people of color live, work, and play, is able to become a healthier, happier place by providing to adequate mental health resources for children and families.

[4 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

5. What does the proposal seek to accomplish? Will it reduce disparities or discrimination?

The community conversations within the communities of color revealed the following are major barriers to seeking and getting mental health:

- Inherent stigma
- Lack of support services and peer support groups
- Lack of access to healthcare and difficulty navigating complex healthcare systems
- Lack of diversity in the healthcare providers who provide their care

This proposal has been designed to address the barriers that prevent children and families from seeking and obtaining behavioral health, mental health and substance use services in the Tri-County Area by developing and implementing programs and initiatives to ensure that the Collaborators can offer affordable, convenient, readily available and trusted services to the community. The proposal will bring increased and updated inpatient care to the area, add additional outpatient programs to avoid hospitalizations and will develop a safe and trusted space where the Collaborators will work collectively to streamline the logistical difficulties that frustrate patients and families and maximize the ability to identify and connect with more children and families in the community who need mental, behavioral or substance abuse services. The care and services contemplated are entirely patient-focused, patient-driven, and patient-centric.

The proposal will also:

- Expand and diversify the mental health workforce in Peoria
- Centralize the intake and support for children and families struggling with behavioral health issues through a coordinated care hub that includes a centralized, easily accessed physical space that can be reached by socioeconomically disadvantaged communities and
- Expand outreach to the schools to provide support for teachers and students to enhance resilience/compassion, raise awareness about mental health and decrease violence/bullying.
- Evaluate the outcomes of this work to determine what is most successful and endeavor to further those efforts while proposing changes to work that is less successful.

[5 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

6. What are negative or unforeseen consequences and positive impacts/opportunities for equity as a result of this proposal? Which racial/ethnic groups could be harmed or could benefit? How could adverse impacts be prevented/minimized and equitable opportunities be maximized?

The Collaborators are confident that this proposal, if funded, will have a substantial positive impact on the Tri-County Area by accomplishing the goals outlined above. Furthermore, the Collaborators will continue to engage with the community conversations to help identify the impact that the interventions have on the community, and help implement an iterative process to respond to negative concerns or issues that are identified by the communities of color.

[6 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

7. Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion?

One long-term goal of this proposal is to recruit and/or retain more skilled mental health providers of color to practice in the Tri-County Area. By developing a pipeline that includes internship programs, outreach to the schools, and ties between Bradley University, Methodist College and the University of Illinois College of Medicine Peoria, the Collaborators hope to engage the youth in these areas, show them career options, and ensure that they can access a path to these careers. The Steering Committee will also endeavor to identify strategies to reach out to and actively recruiting clinicians, therapists, and counselors of color. This could take many forms

including active recruiting at historically African American colleges and universities or other similar strategies to grow and improve diversity among the Collaborators' personnel. This will, over the long run, promote racial equity among the mental health professionals in the area. Further, by having a welcoming, popular and convenient family health center accessible, it is possible that local business (stores/restaurants) would expand to the area and provide revitalization and economic growth to further benefit the area and its residents.

[7 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

8. Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement? Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability?

As this proposal is focused on the mental and behavioral health needs of children and families in the Tri-County area, the Collaborative believes it has devised the most comprehensive and targeted plan to address the racial disparities that exist as it relates to this focus. There is additional work that can be done to further reduce racial disparities and advance racial equity and inclusion in the Tri-County Area, and it will take a multifaceted solution to end these disparities. By addressing one facet - the health and well-being of children and families - the Collaborative believes it will have a positive impact to improve the lives of its clients which will also improve other areas of the community such as education, and employment. With support from the state, including the funding being requested, these additional opportunities can be pursued with meaningful, positive impacts on racial equity and inclusion.

[8 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

9. What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How will the level, diversity and quality of ongoing stakeholder engagement be assessed?

When developing this proposal, the Collaborators were careful to identify and develop realistic, achievable, and sustainable programs and goals. With the engagement of the Center for Health Outcomes Research at the University of Illinois College of Medicine Peoria, the Collaborative will gather and monitor the data necessary to assess the program's efficacy in terms of goal achievement and improved outcomes.

The impacts of this project will be documented by the Center for Health Outcomes Research and through the work of an epidemiologist. First, the specific outcome measures will be identified. This will include but not be limited to outcomes such as: number of ED visits for mental health issues, outpatient follow-up utilization, number of clients seen at the new facility, number of clients receiving community based services, number of mental health providers in the area, diversity of the mental health workforce, number of days of school missed, number of bullying incidents, and many more. In addition to the quantitative assessment, qualitative assessments will be done to provide a complete, multi-methodological picture of the outcomes.

The plan will be to spend the first six months of the funding period collecting and analyzing baseline data. These will serve as the initial metrics to which all subsequent data will be compared. Once programs are being piloted and implemented, data will be collected and assessed every six months to determine how the data points are changing. This evaluation will be conducted over the life of the project, including after the transformation program and funding has expired, to determine the long-term impacts of this program on the community.

The results of these outcomes will be presented to the Collaborators on a regular basis and will be provided to community stakeholders. For those metrics where it appears there has been no improvement, the Collaborators will analyze the data and determine, based on the input from the Steering Committee, what needs to be implemented to improve those outcomes.

[9 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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## 5. Community Input

### HELP AND SUPPORT INFORMATION

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### Service Area of the Proposed Intervention

1. Identify your service area in general terms (e.g., "West Chicago", "East St. Louis Metro Area", "Southeastern Illinois").

The Tri-County Area, which includes Peoria, Tazewell, and Woodford counties, with specific focus on Peoria County and zip codes 61603, 61604, 61605.

**2. Please select all Illinois counties that are in your service area. (NOTE: Selecting a county does not mean that your intervention must service the entire county.)**

**(Hold CTRL+click on a PC or command+click on a Mac to select multiple counties).**

Select counties:

Peoria, Tazewell, Woodford

3. Please list all zip codes in your service area, separated by commas.

Peoria County

61451, 61517, 61523, 61525, 61526, 61528, 61529, 61531, 61533, 61536, 61539, 61547, 61552, 61559, 61562, 61569, 61601, 61602, 61603, 61604, 61605, 61606, 61607, 61612, 61613, 61614, 61615, 61616, 61625, 61629, 61630, 61633, 61634, 61636, 61637, 61638, 61639, 61641, 61643, 61650, 61651, 61652, 61653, 61654, 61655, 61656.

Tazewell County

61534, 61535, 61546, 61550, 61554, 61555, 61558, 61564, 61568, 61571, 61610, 61611, 61635, 61721, 61733, 61734, 61747, 61755, 61759, 62682

Woodford County

61516, 61530, 61545, 61548, 61561, 61570, 61611, 61725, 61729, 61733, 61738, 61742, 61760, 61771.

### Community Input

**Note on the importance of community input:**

*For collaborations to meet the real-world needs of the community members they intend to serve, it's imperative that projects be designed with community member input. We are looking for projects that engaged community members in the design of the intervention being proposed. Methods of community participatory research are encouraged.*

1. Describe the process you have followed to seek input from your community and what community needs it highlighted.

The foundation for this collaborative is built on multiple community needs surveys with the Collaborators.

The University of Illinois College of Medicine Peoria Well-Being Taskforce convened key stakeholders from the medical and educational professional communities on six occasions between October 2019 and August 2020 to review the state of well-being in the medical community and to generate recommendations for various populations and settings. The taskforce identified many challenges, obstacles, and barriers for Peoria-area community members, but developed the following four general recommendations:

**1. Consolidation of Resources:** Most represented areas are under-resourced and there is a notable difference in resource allocation across the different populations. In addition to adding support (see below), the Taskforce recommends the consolidation of resources when available. The creation of a centralized "warehouse" for empirically based resources would reduce both gaps and redundancies. The "warehouse" should be easily accessible to persons leading well-being efforts or who seek well-being resources such as educational presentations, workshops, trainings, counseling, therapy, medication management, and support services.

**2. Uniform Screening Tools:** The Taskforce identified, across all populations, the need for better and greater well-being screening of the medical community. Some populations have no access to screening for well-being, whereas others are screened with non-empirically based measures or tools. Moreover, those who are screened sometimes do not have ready access to the resources needed to adequately address well-being deficits. The Taskforce recommends adoption of a uniform screening tool that

can be employed by all persons in each population served. The tool should be empirically based, user friendly, and match deficits with resources to address them.

**3. Evidence-based Programs:** The Taskforce also underscored the need for provision of evidence-based education and training programs that promote resilience, emotional awareness, and compassion and thereby prevent the onset of burnout, depression, and anxiety. Such skills will prove invaluable to all populations.

**4. Increased Support.** Organizational and administrative leadership should formally support well-being efforts. Leader support should include promoting early access and engagement with well-being education, programming and services across the population represented. Leadership support underscores the value of skills that promote well-being for a successful career in the health fields, while bringing credence to existing skills-building training opportunities. Furthermore, research has shown that organizational and leadership support constitute the strongest predictor of effectiveness for workplace health and well-being initiatives.

As part of the Healthcare Collaborative, a group whose mission it is to improve racial equity around healthcare as mentioned above, UICOMP engaged key stakeholders from the most distressed areas of the community to develop and implement focus-groups to facilitate data-gathering and identify baseline metrics, obstacles and challenges that face the community, and particularly community members of color, related to their healthcare. Ten focus groups comprised of Black/African American and Hispanic/Latinx residents of zip codes 61603, 61604, and 61605 were developed and convened over a two-month period from June 2021 through July 2021.

These focus groups, providing opinions from 85 participants, illustrate that mental health care, for both adults and children, is of upmost concern to the community compared to the other health issues, such as cancer, discussed in the focus groups. Results also confirmed the need to focus on health literacy, improve access and resources particularly for mental healthcare, and enhance diversity among healthcare workers. Additional issues brought up by these groups also mentioned throughout this proposal include:

- The stigma around mental health/healthcare
- The need for providers who listen
- The long wait times for help
- The need for support groups
- The stress and trauma experienced regularly that contributes to mental health problems
- The lack of psychiatrists for children and the lack of resources in schools
- The lack of follow-up for patients released from the hospital
- The stress of being away from friends and family for immigrants to the US
- The anxiety about interactions with police
- The fear of being misled/mistrust in the system
- The frustration with resources in place not always being helpful

Additionally, UnityPlace convened its family community advisory board as well as the Greater Peoria Youth Mental Health Initiative Implementation Board to discuss the perceived barriers to accessing mental healthcare in the Tri-County Area. During these meetings, members shared the following concerns:

- Existing service providers are not able to provide enough services to meet needs.
- Most providers/agencies do not provide post-discharge aftercare education and support, ensure families are equipped to sustain healing, treatment, and progress.
- Youth are transferred to hospitals out of the area because of a lack of capacity.
- Some families are not aware of and/or do not access available services outside of school setting.
- Families and patients are concerned about the stigma associated with seeking healthcare.
- Families do not trust service providers.
- Wait times to enroll in services are too long and are frustrating.
- Service providers do not communicate with clients and families in way that is understandable

UnityPoint Health has worked with community partners to identify barriers and facilitators to developing a large and representative workforce. In June 2021, feedback was solicited both in survey and then compiled and disseminated for an in-person discussion of responses. Partners from UnityPoint, Tri-County Urban League, Greater Peoria Economic Partnership, NAACP, Peoria Fair Employment Commission, New Millennium Institute, Peoria Public Schools, Living to Serve Foundation, County government, Goodwill, Advocates for Access and others identified the following community workforce development needs:

- Continued partnership for job placements and increased internship and apprenticeships
- Community hiring events
- Partnering with Local Community based organizations that provide workforce development and training and building a pipeline to employment with UnityPoint Health
- Communication with community agencies on jobs available and what the hiring process is.
- To be intentional with hiring efforts that target the under-served by becoming a stakeholder in those communities.
- Recruit directly from workforce development programs in the most distressed zip codes in Peoria

The survey revealed that many qualified potential applicants felt that the cost of clothing, lack of childcare, lack of access to a computer and/or lack of transportation prevented them from seeking healthcare-related employment in the Peoria area.

Additionally, responses from this group provided the following directions to improve healthcare equities in Peoria:

- Share all information to other agencies in the community
- Continue educating at-risk populations on preventative health and vaccines

Based on the feedback from the community focus groups, this collaborative believes it has developed a proposal that responds directly to the concerns raised by the frustrated constituents in the target service area.

2. Please upload any documentation of your community input process or findings here. (Note: if you wish to include multiple files, you must combine them into a single document.)

YFBHC Proposal - Section 5. Community Input - UICOMP Focus Group Discussion Slides

**Input from Elected Officials**

1. Did your collaborative consult elected officials as you developed your proposal?

- ☒ Yes  
☐ No

1A. If you consulted Illinois federal or state legislators, please select all legislators whom you consulted.

**(Hold CTRL+click on a PC or command+click on a Mac to select multiple legislators).**

Select legislators:

Bustos, C. - U.S. Representative - 17th Congressional District, Demmer, T. - Ill. Representative - 90th State Representative District, Gordon-Booth, J. - Ill. Representative - 92nd State Representative District, Koehler, D. - Ill. Senator - 46th State Senate District, LaHood, D. - U.S. Representative - 18th Congressional District, Stoller, W. - Ill. Senator - 37th State Senate District

1B. If you consulted local officials, please list their names and titles here.

Peoria Mayor, Rita Ali, Ph. D

Superintendent of Peoria Public Schools, Dr. Sharon Desmoulin-Kherat

Peoria County Coroner, Jaime Harwood, BSN, RN, CFN

Peoria Police Chief, Eric Echevarria

[Input from Elected Officials - Optional] Please upload any documentation of support from or consultation with elected officials. (Note: if you wish to include multiple files, you must combine them into a single document.)

YFBHC Proposal - Section 5. Community Input - Support Letters

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## 6. Data Support

### HELP AND SUPPORT INFORMATION

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**Note on the importance of data in proposal design:**

*It is imperative that applicants use data to design the proposed work. HFS is seeking applications that are "data-first." This means that applicants used data to determine health needs and designed and targeted the proposed work to meet those needs.*

*Examples of relevant data include, but are not limited to, data from the [community data reports](#) produced by UIC, data analysis of healthcare utilization data, qualitative and quantitative surveys, literary reviews, etc.*

1. Describe the data used to design your proposal and the methodology of collection.

This Collaborative relied heavily on the Community Health Needs Assessment ("CHNA") that the Partnership for a Healthy Community conducted in 2019. [\[i\]](#) The Partnership for a Health Community is a community-driven partnership of public and private partners working together to address priority health issues in Peoria, Tazewell, and Woodford Counties. Members include county health departments, the Collaborators and other hospitals, healthcare providers and agencies. As a result of the 2019 CHNA, the Partnership identified four priorities for the Tri-County Area 2020-2022, one of which is Mental Health. [\[ii\]](#) Additional qualitative data from the focus groups conducted by UICOMP, described above and attached hereto, were used. At all groups, notes were taken by medical students on everything that was said, and the notes were the analyzed for themes to determine the most pressing issues raised within and across the groups.

Other Peoria-area studies published by the city and local health department also confirmed many statistics related to how unmet mental health needs is manifesting in the community in the form of suicide and violence. [\[iii\]](#)

The collaborative also relied on its own internal utilization data to identify specific facts and figures regarding the services that are currently being offered, utilized, and delivered in the Service Area. For example, Methodist Medical Center was able to determine that more than 2,600 children and adolescents in need of inpatient behavioral health, mental health, or substance use treatment were either referred out of the community or did not receive treatment due to lack of capacity or a lack of resources to address the patients' acuity. Other Collaborators provided their wait times and caseloads to confirm what gaps exist so that the Collaborators could determine how to overcome those statistics.

As described above in the "Healthcare Challenges" section, data from multiple sources were combined to assess the needs in this region.

It is important to acknowledge that the CDC Vulnerability Index has identified Peoria as a moderate to high level of vulnerability. [\[i\]](#) The target zip codes: 61603, 61604 and 61605 are among the most distressed in the nation. [\[ii\]](#) Furthermore, the target zip codes all contain pockets where social vulnerability is ranked in the highest category for socioeconomic status, race/ethnicity, housing, and household composition/disability. [\[iii\]](#)

Furthermore, the CHNA established distress in the area. In Peoria County, the Median income level is \$53,063 [\[iv\]](#); which is far lower than the state average. The poverty rate for families in Peoria County was reported as 11.3%, which was substantially higher than the state average of 9.8%. [\[v\]](#) The unemployment rate in Peoria County has been higher than the state averages every year from 2013 - 2017. [\[vi\]](#) In 2017, the poverty rate in Peoria County was 15.9%. [\[vii\]](#)

The CHNA also established that Peoria County residents have significant mental health needs. When survey respondents were asked about their overall mental health, approximately 1/3 of respondents admitted they experienced depression or stress in the last 30 days. [\[viii\]](#) 8% of survey respondents described their mental health as "poor"; only 28% of respondents stated that their mental health was "good". [\[ix\]](#)

Despite these admissions, there are insufficient mental health resources in the Peoria County Community to ensure residents are able to receive the mental health care they require. Of the respondents, 67% stated they have not talked to anyone about their mental health. Of those that did talk to someone about their mental health, 38% spoke with a doctor or nurse and 30% spoke to a counselor. [\[x\]](#)

The reasons for not seeking mental health care vary. 31% of survey respondents felt they could not afford the co-pay associated with mental health care; 27% did not seek care because of embarrassment or stigma; 11% had no transportation for care; 18% did not seek care because they lack insurance and 12% did not because their insurance was not accepted. [\[xi\]](#)



These statistics are equally as troublesome for the area's youth. In the Tri-County Area, 31.3% of 10th grade students indicated that in the past 12 months they felt sadness or hopelessness almost every day for at least 2 weeks, causing them to stop participating in some of their usual activities. 16.7% of 10th graders indicated they seriously considered attempting suicide in the past 12 months. [xii] Data from the 2018 Youth Survey measured illegal substance use among adolescents and found that Peoria County is at or above the state averages for substance use in all categories among 8th and 12th graders. [xiii] According to the National Institute of Mental Health ("NIMH") and National Alliance on Mental Illness ("NAMI"), delays in treatment contribute to the fact that 40% of students with mental illness drop out of high school. [xiv] Those same organizations have reported that suicide is the second leading cause of death in children ages 10-34 years. [xv] There is increasing evidence that suicide rates among African American youth are rising. And the associated research emphasizes that the approach to reducing those suicide rates requires an emphasis on culturally competent care and addressing the community stigma and intolerance the youth face regarding mental health treatment and services.

These statistics are consistent with troubling school performance. Peoria High School and Manual Academy also have the lowest graduation rates, at 64% and 62%, respectively. [xvi] (The State average is 85%). In Peoria HS (serving zip code 61604), 40% of students were chronically truant. In Manual Academy (serving zip code 61605), 26.8% of students were chronically truant. [xvii] This is significant because the cause of truancy among high-school students is most likely the result of inappropriate behavior and poor decision-making by the individual students. [xviii] High truancy rates leave children unable to achieve their full potential, which only exacerbates cultural, racial, and socioeconomic disparities.

The Peoria-area schools have been described as having the most segregated public schools of any metropolitan area in the nation. [xix] Peoria also has a high crime and murder rate. The crime rate in Peoria in 2019 was 1.8 times the national average. Peoria has been ranked 15<sup>th</sup> in the nation for its murder rate, which is increasing. [xx] [xxi] From 2017 to 2019, the murder rate doubled. Homicide deaths also impact persons of color disproportionately. [xxii] The two leading causes of death for persons age 15-24 in Peoria County are homicide (52.9%) and suicide (11.8%). [xxiii]

For those that do seek treatment, there are insufficient resources to meet needs.

Methodist Medical Center of Illinois opened Peoria's very first inpatient mental health unit in 1954. Today, as the only inpatient provider for kids in Central Illinois, Methodist Medical Center's child AMI unit is routinely at maximum capacity. And even when the unit is not at capacity, many children cannot be treated at Methodist Medical Center of Illinois because the outdated unit is not equipped to ensure safety for children who display physical aggression and need to be isolated. Specifically, in 2019 and 2020, there were 582 and 598 children and adolescents, respectively, who were referred to other hospitals for inpatient services because Methodist Medical Center of Illinois did not have the capacity or capability to treat them close to home. So far during 2021, 484 children and adolescents have been denied inpatient admission at Methodist Medical Center for the same reasons. Because there are no other inpatient options in the area, patients are forced to seek treatment and get help hours away from home separated from their family in an unfamiliar place. This Collaborative and its proposal will address these capacity and capability issues and provide an updated, modernized space that complies with all current safety requirements while also eliminating an "institutional" feel that exists today. This upgrade will foster a more familiar and healthier continuum of care setting with the added benefits of more integrated, available outpatient services, increased familial education, and amenities designed to reduce barriers and facilitate engagement.

When making referrals for psychiatric evaluation or treatment, Collaborators' clients are often told the area psychiatrists are not taking new referrals; for those psychiatrists that are taking new patients, the waiting list is more than one (1) year. Furthermore, some area psychiatrists do not accept Medicaid coverage. Heartland Health Services (a collaborator) provides services to low- and no-income families and has a much shorter wait time to see a psychiatrist. But, because Heartland Health Services is a Federally Qualified Health Center ("FQHC"), regulations require the patient to transfer their primary care to Heartland and follow one of Heartland's primary care providers to receive and retain the psychiatric referral. Based on the focus group research, families want to be able to see a specialist in a reasonable amount of time without having to change the primary care provider they have come to trust.

For Children's Home (a Collaborator), there is an eight to twelve-month waitlist for a child-client to be seen for in-home therapy because each therapist is carrying a caseload of 13-19 cases across the entire Tri-County area. Children's Home is also averaging 30 pre-admission psychiatric screenings per week on its CARES line.

[i] *Social Vulnerability Index*, supra note i.

[ii] *Id.*

[iii] *Id.*

[iv] CHNA, supra note ii at 21.

[v] *Id.* at 22-23.

[vi] *Id.*

[vii] *Id.*

[viii] *Id.* at 50.

[ix] *Id.* at 49.

[x] CHNA, supra note ii at 48.

[xi] *Id.* at 34.

[xii] *Id.* at 81.

[xiii] *Id.* at 51, 57.

[xiv] 23<sup>rd</sup> *Annual Report to Congress* supra note xviii.

[xv] NAMI, supra note ix.

[xvi] CHNA, supra note ii at 23-24, 26 (*citing* Illinois Report Card, <https://www.illinoisreportcard.com/School.aspx?schoolid=480721500250024>).

[xvii] *Id.*

[xviii] *Id.* at 23-24.

[xix] Vock, D.C. and Maciag, M., *supra* note x.

[xx] Fieldstadt, E., *supra* note xi.

[xxi] *Crime Rate in Peoria, IL*, *supra* note xii.

[xxii] *Peoria County Mortality Report 2019*, *supra* note xiii, at 21.

[xxiii] *Id.* at 10.

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[i] CHNA, *supra* note ii at 22.

[ii] Partnership for a Healthy Community, *1/1/2020-12/31/2022 Priority Mental Health*, (last accessed Nov. 15, 2021), <https://healthyhoi.org/2020-22-Mental-Health>.

[iii] *See Peoria County Mortality Report 2019* *supra* note xiii.

2. Attach the results of the data analyses used to design the project and any other relevant documentation. (Note: if you wish to include multiple files, you must combine them into a single document.)

YFBHC Proposal - Section 6. Data Support - 2019 CHNA and Mortality Report

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## 7. Health Equity and Outcomes

### HELP AND SUPPORT INFORMATION

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1. Name the specific healthcare disparities you are targeting in your service area, including by race and ethnicity. Describe the causes of these disparities that your project specifically seeks to address and explain why you have chosen to address these causes.

Mental health can be impacted by a variety of factors, most of which are out of one's control. One main trigger for a mental health crisis is stress, and stress disproportionately affects populations of color who, in Peoria, tend to be poor, live in areas where more violence happens, have food insecurity, and have been more impacted by COVID-19. These social determinants of health serve as markers of stress in a community and absent the resources needed to mitigate them, the effect can transcend generations. This spiral of stress eventually funnels to affect young children the most because they have not developed mature coping skills and are often unable to access the help they need. These disparities and the impact on racial minorities have been confirmed in the Community Health Needs Assessment for the Tri-County Area.

At Methodist Medical Center, 15.9% (or 200 of 1,257) of the child/adolescent behavioral health admissions involve a patient from one of the three target zip codes. Of those 200 patients from the three target zip codes, 55.5% (111 of 200) are members of a minority (Hispanic/Latino, Black/African American, Multiracial). At the Mental Health Clinic, 27.4% (or 114 of 416) of the treated minors reside in one of the three target zip codes. Of those 114 minor patients, 44.7% are minorities. And for Emergency Department visits, 25% (or 266 of 1066) of the minors presenting for behavioral health related issues are patients from one of the three target zip codes. Of those 266 minor patients, 51.5% were minorities.

Although behavioral health, mental health and substance use disorders do not favor or discriminate against particular races, minorities will experience greater obstacles and barriers to treatment because of various factors, including environmental factors, access to behavioral health and mental health services, cultural stigma, systemic racism. In Peoria, unemployment, poverty, a small provider pool and an even smaller provider pool that accepts Medicaid coverage only contributes to the underlying disparities that disadvantage persons of color.

The focus groups that were led by the Collaborators confirmed that Peoria-area persons of color believe improved mental health must be a top priority for the region.

Given this, and the known lack of providers in the area, particularly those that serve the Medicaid-covered population, and the negative long-term effects of unaddressed mental health issues, this Collaborative believes that coordinated services and increased coverage will be extremely beneficial to the Community, and its residents of color.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

To address these disparities and increase access to child and adolescent mental health and substance use disorder services, the Collaborative will coordinate among the involved agencies to:

- Increase the number of available counselors, therapists, psychiatrists, and other providers to increase access and decrease wait times for services
- Ensure all additional counselors, therapists and other providers that are hired as part of The YFBHC accept Medicaid coverage
- Design and build a coordinated treatment and community center, the Hub, that will provide the entire spectrum of services addressing child and adolescent behavioral health in a convenient, local community center within the target zip codes
- Ensure transportation and day care services are available so that families are not prohibited from taking a child to an appointment or service because they cannot access or afford transportation or childcare
- Hire and train Family Navigators to address insurance issues, arrange for convenient, stacked appointments to minimize parents' time away from work and other obligations
- Develop and implement a shared assessment to be used among providers and offered to pediatricians/primary care providers to facilitate early diagnosis and intervention
- Develop a shared service plan that addresses social determinants of health to ensure the patient and family have adequate and appropriate food, shelter, transportation, support, and safety to succeed in their treatment plan and avoid further trauma and crisis
- Recruit staff, navigators, counselors, therapists, and clinical professionals of color who will serve low-income families and foster patient comfort and trust

Once operational, the Collaborative will measure how many individuals are being served in the various settings and the impact those services are having on various outcomes. The Collaborative will measure how many times an individual has accessed a single touch point, patient satisfaction, and how many organizations are coordinating care or referring clients to this coordinated care hub. Additionally, a cost analysis will be done to determine the overall financial benefit of this coordinated care model.

The goal of engaging with the schools and community will allow agencies to meet individuals where they are. School outreach will provide services to larger groups of

children and teachers, training them to be more resilient and tolerant. This school-based program will also encourage discussions about mental health to reduce stigma. The impacts of these community care models can be measured by the number of ED visits related to behavioral/mental health, the number of suicides and attempts, the number documented bullying/fighting incidents at a given school, as well as truancy rates.

Our long-term goal is to get more providers, including providers of color, to work in Peoria and serve our community. The Steering Committee will develop strategies to actively recruit clinicians, therapists, and counselors of color. This could take many forms including active recruiting at historically African American colleges and universities or other similar strategies to grow and improve diversity among the Collaborators' personnel. Furthermore, through its workforce development program, the Collaborators have been and will continue to reach out to communities of color to provide resources and assistance to pursue jobs and careers in the healthcare field. As the Collaborative takes shape, it will monitor the workforce and identify who is practicing in the area, who is accepting Medicaid, and how the racial/ethnic make-up of this population is changing. Diversity will be not be achieved immediately; however, after many years of increasing the number of providers through added fellowship programs, internship programs, and opportunities for persons and students of color to advance, this will have a broad impact for the community where people will no longer have to wait for appointments, where the healthcare workforce looks more like the community being served and where people will have a choice in therapist so they can best find someone who is able to help them/their families in a mental health crisis or on a regular basis.

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

3. Why will the activities you propose lead to the impact you intend to have?

This Collaborative and its proposal are entirely patient-centric. By refocusing our efforts on why patients and families cannot or do not seek care for follow-through on care, and eliminating the causes of those frustrations, fears and obstacles, this vulnerable population will be brought closer to equal access to mental health, behavioral health and substance use disorder treatment.

The development of this Collaborative has brought critical services together and initiated a dialogue that is focused on improving the delivery of care and services to the Tri-County Area by removing barriers and improving impact. These meetings have given the Collaborators opportunities to learn more about each other and how they can connect their clients and patients into other Collaborators' programs. By fully funding and operationalizing this program, the Collaborators will be able to train the Family Navigators to make the same connections for patients and families on a consistent basis. The improved and enhanced coordination among the Collaborators will translate into greater coordination in the Community. Coordination of care will save families time, frustration, money and travel, which, although it is not enough to raise someone out of poverty, will hopefully help parents miss fewer hours of work and have more time available to tend to other needs. Having a central location where providers can coordinate and patients can access all the services and resources they require, this Collaborative will take an overwhelming care model and deliver a more integrated, efficient, and understandable program. By reaching out to the schools and into the community, the Collaborators will be able to provide services where they are needed, without burdening individuals with finding transportation to various locations. This will also save parents time and money, which would substantially help our vulnerable populations. This will allow the Collaborators to address the needs of a child/family holistically, which has the potential to substantially improve the quality of life and improve the community at large.

Finally, by increasing the number of providers and providers of color, this will not only decrease waiting times for appointments, but it will also increase the number of practices in town, which will increase the odds that a service, a therapist or other unmet need will be more easily accessible. By diversifying our workforce, the Collaborative will meet the needs of the community that want to see more providers who "look like them" and who "speak the same language." By hearing this concern and addressing it through a professional pipeline program, the Collaborative will ensure that not only are there providers who are available to take new patients, but that some of these providers will be of color, which can in some cases instantly increase trust and understanding between patient and provider.

By helping Peoria's youth achieve improved mental and physical health, the Community will see improved school performance, which lends to a more successful workforce. This, in turn, will improve the economy, which will further improve healthcare access and opportunities and make further inroads in the systemic inequities that exist all around the Tri-County area, but especially in Peoria area zip codes 61603, 61604 and 61605.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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## 8. Access to Care

### HELP AND SUPPORT INFORMATION

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- If you'd like to consult support resources provided by Amplifund: Visit the vendor's [support website](#) for user guides, tutorial videos, and other resources. You will have to register a new and separate account to access content on this site.

1. Name the specific obstacles or barriers to healthcare access you are targeting in your service area. Describe the causes of these obstacles that your project specifically seeks to address and explain why you have chosen to address these causes.

The CHNA clearly defines and describes the issues and obstacles that Peoria-area families experience with access. Regardless of need, the area's children are unable to receive necessary services because there are not enough providers that accept their insurance, because of long wait times for appointments, because of a lack of transportation, and because the patients and families are concerned about the stigma associated with mental health and behavioral health treatment.

Another obstacle to care is the lack of a coherent system of intake and follow-up for children and adolescents in need of mental health care. This lack of cohesion can send families bouncing from one agency to another, doing similar intakes after long waits, and getting discouraged and sometimes giving up before their needs have even begun to be met. This is not acceptable, particularly given the vast needs of this community that have only become more apparent and exacerbated during the pandemic.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

This Collaborative's proposal will increase access to care in Peoria by:

- Increasing the number of available inpatient beds in the area from 23 to at least 43 beds
- Creating the region's first and only behavioral health ICU so that the highest acuity children and adolescents do not need to be transferred more than 75 miles away to Springfield or Rock Island.
- Increasing the number of psychiatrists and counselors available to serve Medicaid beneficiaries, thereby reducing wait times for appointments
- Establishing the first unit specializing in the care of children with autism and Asperger's
- Developing an intensive outpatient program to reduce inpatient admissions
- Creating a 24/7 crisis center to provide intervention services to families and avoid unnecessary Emergency Department visits
- Bring all local services into a central, local, convenient location where families can all receive treatment, support, and social services
- Utilize Family Navigators to streamline and stack appointments to minimize disruption and time away from school, work, and other obligations
- Provide transportation and day care services so no family must cancel an appointment because they cannot obtain or afford these necessary services
- Hire and train Family Navigators to address insurance issues, arrange for convenient, stacked appointments to minimize parents' time away from work and other obligations
- Build a pathway to increase the number of qualified providers that are committed to serving low-income patients and families
- Ensure all services provided under The YFBHC are covered by Medicaid
- Bring these services into the most vulnerable neighborhoods to foster trust and comfort for those disenfranchised by "the system."

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

3. Why will the activities you propose lead to the impact you intend to have?

The YFBHC came together to find the root causes related to healthcare access in the community and worked together to develop realistic, transformational plans to eliminate barriers and obstacles for accessing care.

Implementing coordinated shared tools from a centralized location will improve care coordination and reduce inefficiencies and redundancies that plague the existing "system" and consume providers' valuable time and resources. By reducing these inefficiencies and creating more capacity to deliver effective services, this Collaborative will increase access to care by ensuring that individuals are maximizing their time with the right providers who have the right information in the most conducive setting – the Hub, a school or in the patient's home.

By increasing the number of providers, including providers of color, waiting times for appointments will be decreased, and more children will be able to be seen when they need care. Currently, individuals from wealthy families can see private therapists, while socioeconomically disadvantaged individuals do not have this luxury and are often waiting for weeks to months for appointments with the limited number of providers who may take Medicaid. Changing these numbers and specifically encouraging new practitioners to serve the underserved populations will ensure that everyone has access to care when it is most needed. Although not part of this proposal, one ideal goal is to incentivize serving those in need.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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## 9. Social Determinants of Health

### HELP AND SUPPORT INFORMATION

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**Note on the significance of social determinants of health:**

*A full 50% of a person's health outcomes can be attributed to social determinants of health (that is, factors such as education, economic stability, housing, access to healthy food, access to transportation, social support and environment). Given this, we are looking for collaborations that meaningfully address social determinants of health in coordination with physical and behavioral health.*

1. Name the specific social determinants of health you are targeting in your service area. Describe the causes of these social determinants that your project specifically seeks to address and explain why you have chosen to address these causes.

This Collaborative serves patients and families every day that must confront and overcome multiple social determinants of health. Unique to child and adolescent behavioral health is the fact that patients in crisis are often part of a family in crisis. It is not enough to assume a family can make and keep healthcare appointments for a child. Unfortunately, a child's behavioral health needs may be given a lower priority when income, food, housing, and safety are unstable. Addressing social determinants of health ("SDOH") is foundational to ensuring a child can obtain and follow-through on a service plan and is critical to ensuring the patient's family can support the child on their healing journey. The YFBHC will work to ensure there are available services in the community, based out of the family center and coordinated care hub, to provide food bank and nutrition services, primary care, therapy services, substance abuse services, parent training/education, suicide prevention and awareness services, LGBTQ+ supports, exercise classes, support groups, and other services identified by the YFBHC governance during the course of the project.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

The YFBHC will address the social determinants in many ways.

At the center is the Family Navigators and the shared service plan. For those children and families in crisis, the navigator will be trained to identify SDOH and connect the patient and family to those necessary resources to ensure the child and family can work towards ensuring adequate income, food security, safety and housing.

The Collaborators all provide a broad range of clinical and social services that can address a family's SDOH needs regardless of severity. The shared service plan will include these SDOH so that the treatment team – whether it be one provider or more – can be mindful of these issues and incorporate these SDOH in a whole-person, whole-family approach to the child's care.

The delivery of SDOH services will be monitored by the Collaborative by the Center for Health Outcomes Research and through the work of an epidemiologist. In addition to other metrics, this collaboration will be identifying and analyzing data and outcomes related to the number of clients receiving community-based services, including the type. This will allow the Collaborative to monitor how they are impacting SDOH and what other services may need to be incorporated more fully.

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

3. Why will the activities you propose lead to the impact you intend to have?

For a patient or family to be engaged in treatment and progress towards sustained healing, they must be able to commit to the service plan without experiencing further trauma. By establishing a point of contact, the Family Navigator, who can facilitate services and resources to provide stability and support, the patient and family can avoid further trauma and remain focused on continuing the necessary treatment that will only enhance their collective ability achieve, grow and succeed.

When everyone, regardless of skin color, has access to a mental health provider when they need it, and when they can be seen promptly, and when they can receive care in a convenient, accessible setting, the Community will improve with healthier, happier, thriving children and families. By using this three-pronged approach of coordinating/centralizing care, conducting more outreach in the schools, and creating a pipeline to increase diverse mental health practitioners, this Collaborative will ensure that the burdens of lack of access to care, lack of access to education, and the lack of a supportive social/community environment, will be eased in the Tri-County Area.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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## 10. Care Integration and Coordination

### HELP AND SUPPORT INFORMATION

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1. Describe how your proposal improves the integration, efficiency, and coordination of care across provider types and levels of care.

All providers, including these Collaborators, can agree that siloed and fragmented care reduces quality, increases costs and results in poor outcomes. This proposal, a true collaborative, brings together social and clinical providers to serve patients "under one roof" in a model that will share assessments and service plans so that each individual provider can deliver their specific service with an understanding and appreciation for the other services that the patient is receiving. This model that connects the Collaborators will ensure the rights services, in the right place, at the right time for the patient and their family.

Furthermore, by collectively adopting an evidence-based practice, patients' providers will speak the same language, use similar techniques, and focus on similar goals. As a patient and family transitions between services and treatments as they progress to lower acuity services, that shared evidence-based practice will provide consistent tools and strategies that the patient and family can internalize and use up to and beyond their graduation from the Collaborators' services. That consistency through a coordinated approach will provide an improved patient experience, which will only foster increased engagement.

These Collaborators have come together to work closely to break down barriers and reform the way they can deliver care. Knowing they can work closely to re-envision how they deliver care. The Collaborators are confident and motivated to operationalize these transformative ideas and continue to work closely together for the benefit of individual patients and their families.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2. Do you plan to hire community health workers or care coordinators as part of your intervention?

- ☒ Yes  
☐ No

2A. Please submit care coordination caseload numbers and cost per caseload (stratified by risk, if applicable).

Care Coordination will be provided by the Family Navigators. Based on estimates from collaborators' care coordination experience, and average caseload of 20 Collaborative-defined eligible families/navigator will be maintained. For families with high acuity needs, a caseload of 12 Collaborative-defined eligible families/navigator will be maintained. Duration of Family Navigator involvement will depend on specific family needs, in combination with the Collaborations' pending definition of care coordination graduation. Family Navigators will be hired in year 1 of funding at an initial annual rate of \$48,713, indicating an average cost per caseload of \$2,435 for most families and \$4,059 for those with higher acuity needs.

These estimates are based on Family Navigator involvement for a full year. However, it is expected that as Collaborators establish organizational integrated practices, families will feel empowered, informed, and knowledgeable to graduate from the care coordination program in a shorter amount of time.

[2A - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

3. Are there any managed care organizations in your collaborative?

- ☐ Yes  
☒ No

3A. If no, do you plan to integrate and work with managed care organizations?

- ☒ Yes  
☐ No

3B. Please describe your collaborative's plans to work with managed care organizations.

All Collaborators that are eligible for certification with Medicaid provide covered services and serve managed care members currently. As this collaborative is committed to expanding covered services, the Collaborative will continue to work with Managed Care Organizations to ensure its members are provided increased access to quality, covered services.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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## 11. Minority Participation

### HELP AND SUPPORT INFORMATION

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1. Please provide a list of entities that will be a part of your collaboration/partnership that are certified by the Illinois Business Enterprise Program (BEP) and/or not-for-profit entities majorly controlled and managed by minorities that will be used on the project as subcontractors or equity partners.

**Note on BEP partners/vendors:**

*If one of the members of your collaboration already contracts with a BEP-certified firm or a not-for-profit entity that is majorly controlled and managed by minorities, only include the services of the firm that will be used on this project. To be included, these services must increase the entity's volume of work above the level of services already provided to the collaborating member.*

**Resource to help you search for/identify BEP-certified vendors in Illinois:**

*If you are seeking BEP-certified entities to partner/collaborate with, you may consult our resource guide linked below on How to Look Up BEP-Certified Vendors in the State of Illinois.*

Download resource:

[How to Look Up BEP-Certified Vendors in the State of Illinois.pdf](#)

List entities here:

Tri-County Urban League, a Collaborator, is a not-for-profit entity majorly controlled/managed by minorities.

The Hult Center for Healthy Living, a Collaborator, is led by an African American female.

The University of Illinois College of Medicine – Peoria, a Collaborator, is managed by a minority Interim Dean.

When possible, the YFBHC will solicit proposals from small and minority businesses, and women owned businesses. The following steps will be followed to ensure these types of business enterprises are used when possible:

- Place qualified small and minority businesses, and women's business enterprises on solicitation lists, and ensure they are solicited whenever they are potential sources.
- When feasible, divide purchases into smaller quantities to permit participation by these business enterprises.
- When feasible, allow for delivery schedules that allow for participation by small and minority businesses, and women's business enterprises.
- Appropriately use the services of organizations such as the Small Business Administration, and the Minority Business Development Agency.
- Require similar action steps for prime vendors in their selection of sub-contractors when applicable.

The University of Illinois adheres to a Supplier Diversity Program and works with only BEP certified vendors and will extend that commitment into this collaborative.

2. Please describe the respective role of each of the entities listed above, and specify whether they will have a role only during the implementation of your proposal or if they will have a role in the ongoing operation of your transformed delivery system.

Both Tri-County Urban League and the University of Illinois College of Medicine Peoria are Collaborators in this project. As Collaborators they will participate in the governance structure that develops the programming and services described in and throughout this proposal as well as monitor for goal achievement. Additionally, the University of Illinois College of Medicine Peoria will provide substantial support with data aggregation and outcome measurement for purposes of reporting results to HFS.

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

**Note for those wishing to apply for BEP certification:**

We recognize that some individuals encountering this application may wish to gain BEP certification. Follow this [link to the state's Business Enterprise Program webpage](#) to begin the application process.

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## 12. Jobs

### HELP AND SUPPORT INFORMATION

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### Existing Employees

1. For collaborating providers, please provide data on the number of existing employees delineated by job category, including the zip codes of the employees' residence and benchmarks for the continued maintenance and improvement of these job levels.

Please see the attached file that has been uploaded with this proposal.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

YFBHC Proposal - Section 12. Jobs - Existing employees by category and zip code

### New Employment Opportunities

2. Please estimate the number of new employees that will be hired over the duration of your proposal.

92

3. Describe any new employment opportunities in the future alignment of your proposal and how those opportunities reflect the community you serve.

Throughout 2021, Collaborators launched a community partner survey to understand and explore the barriers to healthcare-related employment that exist in the area and what steps can be taken to assist the respondents with applying for healthcare related jobs in the Service Area and what can be done to make the hiring process more inclusive.

The survey revealed that many qualified potential applicants felt that the cost of clothing, lack of childcare, lack of access to a computer and/or lack of transportation prevented them from seeking healthcare-related employment in the Peoria area.

Job coaching, mentoring and assistance with the processes associated with hiring were identified as the most helpful resource that could assist with employment.

Furthermore, the respondents communicated that they would be more inclined to pursue healthcare-related employment if they were exposed to more information about the positions, the process the benefits and the accessibility. For example, most of the Hispanic families in Peoria are immigrants with first-generation children who seek employment based on what they and their peers in the community see and know. There are opportunities to develop a more diverse and inclusive workforce by partnering with local community-based organizations – like those in this collaborative – to provide workforce development and training and building a pipeline to employment in the healthcare industry. The focus group also identified that informational videos are highly effective in communicating information (in multiple language) to a diverse audience. The videos can address opportunities but also provide answers to the questions potential applicants have related to benefits, costs, time, transportation, schedules, immigration concerns and the like. By sharing more information and allaying concerns, more persons of color from different backgrounds can find a path to employment in healthcare and with the Collaborators here.

This collaborative plans to hold hiring events in specific communities, providing language interpreters to connect with a more diverse workforce and provide a more communicative application process, including feedback when a position is not offered, will foster comfort among persons and cultures who would typically not consider employment with a healthcare provider or in the healthcare field.

Child and Adolescent Inpatient Center

- 7.0 FTE RNs
- 3.0 FTE Masters Level Clinicians
- 4.0 FTE Child Psychiatrist
- 17.5 FTE MHAs or CMAs
- 4.8 FTE program assistants or CNAs
- 1.0 FTE Recreational therapist
- 7.4 FTE Security
- 0.5 FTE Chaplain
- 12.0 FTE Kitchen
- 4.6 FTE EVS
- 0.5 FTE Nutritionist

Methodist Medical Center – Outpatient Staffing

- 1.8 RN
- 3.0 MOA
- 3.0 Master Level Clinicians

Community Outreach

- 5.0 FTE Family Navigators

In-School Health Programs

- 1 APN for East Peoria SBHC
- 1 APN for Pekin SBHC
- 1 CMA for East Peoria SBHC
- 1 CMA for Pekin SBHC
- 6 LCPC/LCSW for PPS

Child and Adolescent Psychiatry Fellowship

- 2 Double-Board Certified CA psychiatrists
- 1 Program Coordinator
- 2 Child and Adolescent Fellows/year for two years (years 4-5)

Outcome measurement

- 0.2 FTE for director of the Center for Health Outcomes Research (MD or PhD)
- 0.25 FTE for statistician (PhD)
- 0.5 FTE for research assistant (BA/BS)

Collaborative Administration

- 1.0 FTE Collaborative Coordinator

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

4. Please describe any planned activities for workforce development in the project.

The Collaborative plans to develop materials and videos to reach into the community share the opportunities that exist. The Collaborative will hold hiring events in specific communities, providing language interpreters to connect with a more diverse workforce and provide a more communicative application process, including feedback when a position is not offered, will foster comfort among persons and cultures who would typically not consider employment with a healthcare provider or in the healthcare field.

The YFBHC will also support the development of a child and adolescent psychiatry fellowship. A new YFBHC's child and adolescent psychiatry fellowship will be an attractive recruitment vehicle for adding the requisite UICOMP faculty members, while adding service through relatively low-cost trainees. Most important, the creation of a fellowship program will serve as a pipeline for recruitment of graduate trainees. Trainees interested in this field will have the opportunity to continue their training and forge professional relationships in their local community, thereby increasing the probability that these homegrown physicians will remain in the Tri-County area.

[4 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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### 13. Quality Metrics

#### HELP AND SUPPORT INFORMATION

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#### Alignment with HFS Quality Pillars

In order to complete this section, you will need to reference the HFS Quality Strategy document linked below.

HFS Quality Strategy:

<https://www.illinois.gov/hfs/SiteCollectionDocuments/IL20212024ComprehensiveMedicalProgramsQualityStrategyD1.pdf>

1. Tell us how your proposal aligns with the pillars and the overall vision for improvement in the Department's Quality Strategy.

The YFBHC aligns with three (3) of the five HFS Quality Pillars: Child Behavioral Health, Equity, and Improving Community Placement.

This proposal incorporates and operationalizes all of HFS' vision to improve behavioral health services and supports for children. This proposal will improve integration of physical and behavioral health by aligning and involving social and clinical supports in a shared service plan with the assistance of a family navigator to aide patients and families in utilizing the available services and supports available. The proposal will also improve transitions of care from inpatient to community-based services by developing the central, convenient, comfortable inpatient and outpatient community center. Bringing inpatient, outpatient, and social services under one roof will increase alignment and assist families in coordinated, smooth transitions between levels of acuity and service. Additionally, the proposal will develop and grow services designed to reduce hospitalizations and provide high-acuity and crisis interventions without having to send a patient to the emergency department.

The proposal aligns with the HFS goal of serving more people in the setting of their choice, and through the hub and spoke model there will be both centralized and expanded care, covering all locations including schools, in-home services and other community-based services and supports.

The use of evidence-based practice to coordinate care and centralize intakes, will serve as a model to attract new providers and create a state-of-the-art program, better than any in the region, for the benefit of a community in a high-vulnerability area.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

#### 2. Does your proposal align with any of the following Pillars of Improvement?

2A. Maternal and Child Health?

- ☐ Yes  
☒ No

[Maternal and Child Health - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2B. Adult Behavioral Health?

- ☐ Yes  
☒ No

[Adult Behavioral Health - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2C. Child Behavioral Health?

- ☒ Yes  
☐ No

Child Behavioral Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.

1. Outpatient follow-up after behavioral health hospitalization or ED visit at 7-days and 30-days

2. Crisis response services that result in hospitalization
3. Visits to ED for behavioral health services that result in hospitalization
4. Overall number and length of behavioral health hospitalizations
5. Number of repeat behavioral health hospitalizations

[Child Behavioral Health - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2D. Equity?

- ☒ Yes  
☐ No

Equity: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.

1. Reduced hospitalizations among minorities in target zip codes
2. Reduced inpatient transfers to hospitals outside the service area
3. Increased utilization of Medicaid-covered behavioral health, mental health and substance use services in the target zip codes

[Equity - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2E. Community-Based Services and Supports?

- ☒ Yes  
☐ No

Community-Based Services and Supports: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.

1. Increased utilization of Medicaid-covered behavioral health, mental health, and substance use services in community-based settings (i.e. school and in-home care)
2. Number of mobile crisis response screenings
3. Reduction in re-admissions

[Community-Based Services and Supports - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

3. Will you be using any metrics not found in the quality strategy?

- ☒ Yes  
☐ No

3A. Please propose metrics you'll be accountable for improving and a method for tracking these metrics.

1. Reduced DCFS referrals
2. Reduced suspensions/expulsions for schools

[3A - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

**Note: Once metrics are agreed upon in the negotiated funding agreement, HFS will proceed to establish a baseline for the service community, a tracking process, and negotiated improvement targets.**

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## 14. Milestones

### HELP AND SUPPORT INFORMATION

**Note on work process:** We strongly recommend that applicants draft responses to long-form narrative questions locally (i.e. in Microsoft Word) and then copy and paste these responses into Amplifund. Many Amplifund response fields will preserve formatting (e.g. a table, bullet list, or text style) copied from word processing applications, allowing applicants flexibility in how they format their responses.

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- If you need technical support in Amplifund, email [support@il-amplifund.zendesk.com](mailto:support@il-amplifund.zendesk.com) with your question. All emails sent within business hours (7am-5pm) should receive a response within two hours.
- If you'd like to consult support resources provided by Amplifund: Visit the vendor's [support website](#) for user guides, tutorial videos, and other resources. You will have to register a new and separate account to access content on this site.

For all activities described in your proposal, please provide a calendar of milestones to show progress (e.g., when IT will be purchased, when IT will be operative, when construction projects will begin and end, when people will be hired, etc.) The timeline should be in months from award.

- Family Navigator Program
  - Months 1-5: Develop program metrics and benchmarks (Months 1-5)
  - Months 6-9: Recruit Family Navigators (Months 6-9)
  - Months 9-12: Train Family Navigators (Months 9-12) *\*to coincide with shared assessment being completed*
  - Beginning Month 12: Implementation of Family Navigator Program
- Shared Practice Tools
  - Months 1-3: Purchase evidence-based practice
  - Months 4-6: Train personnel on evidence-based practice
  - Months 7-10: Develop shared assessment tool
  - Months 9-12: Develop shared service plan
  - Beginning Month 12: Implementation of evidence-based practices and shared tools
- Internships
  - Months 1-6: Planning (identify positions and quantity)
  - Months 4-12: Recruiting
  - Beginning month 10: Implementation of interns
- Fellowship Program
  - Months 1-12: Recruit core faculty, develop fellowship program and apply for accreditation
  - Months 13-16: Waiting period for approved accreditation
  - September 1 following receipt of accreditation: Fellowship recruitment begins (Fellowships follow a standard annual cycle will recruiting occurring from September – January each year. Fellows are selected in January and the Fellowship begins on July 1 each year).
- Program Evaluation
  - Months 1-6: Baseline data collection
  - Months 6-9: Baseline data analysis
  - Months 10-12: Baseline results reporting
  - Months 13-14: Data acquisition begins
  - Months 15-16: Data analysis begins
  - Months 17-18: Dissemination, discussion and review of data begins
  - The evaluation process will be repeated every six months
- Family Hub and Community Center
  - Months 1-3: Purchasing/Closing on property
  - Months 2-5: Design
  - Months 5-7: Bids
  - Months 5-9: Permits
  - Months 9-23: Construction
  - Months 22-24: Licensure, Certifications, Occupancy and other Approvals
  - Month 25: Opening of Hub and Community Center.

[Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

YFBHC Proposal - Section 14. Milestones

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## 15. Budget

### HELP AND SUPPORT INFORMATION

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### 1. Annual Budgets across the Proposal

In order to fill out budgets correctly, please view these [technical video instructions](#) for completing a budget.

Use the Excel template below to list the line items of your budget. Working within one single Excel file, fill out sheets for each year that you are requesting funds.

Please check that all totals are correctly calculated, especially if you have added new rows to the spreadsheet. Applicants are responsible for submitting accurate totals. *Note: This spreadsheet has been locked, but not password protected.*

Some aspects of your budget request may be funded out of state capital dollars and not transformation funds. HFS will make decisions on funding source. Include all expenses for which you seek reimbursement in your budget regardless of funding source

**NOTE: Your budget should demonstrate a clear ramp down of reliance on Transformation funding and a ramp up of reimbursements for services and other funding sources that show sustainability over time.**

HTC Annual Budgets Template

HTC Budget Template.xlsx

When completed, please upload your spreadsheet here.

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[Budget - Optional] Please upload here any additional documentation or narrative you would like to provide around your budget. Include any documentation regarding budget items in the Construction category (drawings and estimates, formal bids, etc.) (Note: if you wish to include multiple files, you must combine them into a single document.)

### 2. Number of Individuals Served

Please project the number of individuals that will be served in each year of funding.

Year 1 Individuals Served

2100

Year 2 Individuals Served

2250

Year 3 Individuals Served

2700

Year 4 Individuals Served

2700

Year 5 Individuals Served

2700

Year 6 Individuals Served

2700

### 3. Alternative Payment Methodologies

Outline any alternative payment methodologies that your proposal might utilize for receiving reimbursement for services from MCOs.

No alternative payment methodologies have been identified at this time. The collaborative, however, is willing to work with managed care organizations to develop strategies and programming to maximize the project goals and would be open to possible alternatives.

[Alternative Payment Methodologies - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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## 16. Sustainability

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Include a narrative that describes how your budget will decrease reliance on Transformation funding over time and how reimbursements for services and other funding sources will increase and establish sustainability over time. (i.e. how will your project continue to operate without HTC funding?)

In particular, include how services that address social determinants of health will be funded on an ongoing basis (for example, through existing payment models, alternative payment methodologies for Medicaid services, or through other funding sources).

In your narrative, highlight any key assumptions that are critical to making your project sustainable.

Provide your narrative here:

The YFBHC is requesting transformation funds to build out the spaces and systems that will allow the existing Medicaid-certified providers to continue to deliver care and services that are covered by their existing relationships with Managed Care Organizations and other payors. Although the initial investment in capital improvements, staffing and training will be significant, those expenditures – which will increase efficiency, coordination and outcomes - will allow the Collaborators to deliver more care and services that are already covered by Medicaid or other sources, thereby achieving sustainability.

To the extent the Collaborative has not yet achieved full sustainability as planned when the Transformation Funds have been exhausted, the Collaborative is identifying options and solutions to ensure the work of the Collaborative remains fully funded beyond the Transformation Program for the betterment of the Tri-County community for many years to come. For one, UnityPoint Health will work with the UnityPoint Health – Central Illinois Foundation to develop a fundraising program to ensure ongoing sustainability beyond the Transformation Program. Similarly, the Gilmore Foundation has expressed interest in working with the Collaborative and investing in this proposal and its solutions to address the immediate behavioral health crises in the region as well as its plan to advance a diverse, sustainable workforce for mental behavioral health treatment services.

[Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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